Your Heart
Our Hands

CENTRAL GEORGIA
HEART & VEIN CENTER

PATIENT DEMOGRAPHIC SHEET

Last Name:_____ First Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone #:_____ Cell Phone #:_____

Work Phone #:_____ Emergency Phone #:_____

Date of Birth:_____ Social Security #:_____

Sex: ☐ M ☐ F ☐ Other, please specify:_____

Marital Status: ☐ S ☐ M ☐ D ☐ W Spouse's Name:_____

Email Address:_____

Emergency Contact

Name:_____ Phone:_____

Please list who we may release information to:

_____

_____

Primary Insurance

Company Name:_____

Policy Number:_____

Group Number:_____

Subscriber's Name:_____

Subscriber's DOB:_____

Secondary Insurance

Company Name:_____

Policy Number:_____

Group Number:_____

Subscriber's Name:_____

Subscriber's DOB:_____

_____ _____

Signature of Patient or Patient's Representative Date

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PAST MEDICAL HISTORY

Patient Name: _____ Date: _____

Please place a check mark next to any illnesses that apply to you.

Do you have a history of any of the following:	PHYSICIAN USE
☐ Heart disease (heart attack, coronary artery disease, angioplasty, stents, bypass surgery) if yes, please circle	
☐ High blood pressure	
☐ High cholesterol	
☐ Diabetes	
☐ Stroke	
☐ Vascular disease (blockages in the legs or neck) if yes, please circle	
☐ Heart murmur	
☐ Mitral valve prolapse	
☐ Rheumatic fever	
☐ Hypothyroidism (low thyroid)	

PAST SURGICAL HISTORY (List all surgeries and date peformed)

DATE	SURGERY	DATE	SURGERY

DIAGNOSTIC TESTING

Have you had any of the following tests performed?	YES	NO	DATE	WHERE
Stress Test				
Echocardiogram (ultrasound of the heart)				
Cardiac Catheterization				
Chest X-ray				

ALLERGIES

1. Are you allergic to any medications? ☐ Yes ☐ No
2. Are you allergic to Iodine? ☐ Yes ☐ No
3. If you have any allergies, please list all of them: _____

_____

_____

SOCIAL HISTORY

1. Are you ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
2. How many children do you have? _____
3. What is your present occupation? _____
4. Do you use tobacco products? ☐ Yes ☐ No

   If yes, which product? _____

   How often? _____
5. Do you drink alcohol? ☐ Yes ☐ No

   If yes, how often and how much? _____
6. Do you have a history of substance abuse? ☐ Yes ☐ No

FAMILY HISTORY

Is there a family history of any of the following?	YES	NO	COMMENTS
Heart Disease (heart attack, coronary artery disease, blockages, bypass surgery, angioplasty, stents)			
High Blood Pressure			
Diabetes			
Stroke			

FOR NEW AND RETURNING PATIENTS, PLEASE ANSWER THE FOLLOWING QUESTIONS

Have you had any lab work performed recently, or since your last visit? If yes, where?

_____

Have you been admitted to the hospital or visited the ER? If yes, why and what Hospital?

_____

_____

Have you seen your primary doctor or a specialist since your last visit?

If yes, Why? _____

Where? _____ Dr. Name and/or Specialty _____

Signature: _____ Date: _____

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MEDICATION HISTORY

Name: _____ DOB: _____

Please list all of the medications (both prescription and non-prescription medications) that you are currently taking:
For example, do you take medications such as Motrin, Ibuprofen or Advil?

Medication	Dose	How often

Please list your Preferred Pharmacy:

Name_____ Address _____Phone _____

HOSPITALIZATION HISTORY

Please list your most recent hospitalizations:

When: _____

Where:_____

Why: _____

PHYSICIAN HISTORY

Please list the complete name of all the physicians that you currently see:

Physician	Phone Number

PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT

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CONSENT TO MEDICAL TREATMENT

In consideration of medical services to be rendered to me (herein referred as a Patient) at Central Georgia Heart & Vein Center (herein referred to as CGHVC), Patient does hereby consent as follows:

1. Consent and Treatment Authorization

Patient (or the undersigned acting on behalf of Patient), who is requiring medical treatment, does hereby consent to the rendering of such care and treatment, which may include diagnostic procedures and such medical treatment and care as the Attending Physician or other physicians of CGHVC medical staff consider to be necessary and appropriate.

The consent to receive medical treatment includes, but is not limited to, examinations, diagnostic and therapeutic procedures, medications, infusions, and any other medical treatment services which Patient may require.

In the event that CGHVC should decide that blood specimens should be provided by the Patient for testing purposes and in the interest of the safety of those with whom Patient may come in contact, Patient does hereby consent to such blood withdrawal and for the testing thereof, as well as the release of test information where this is deemed medically appropriate or required by law.

2. Disclaimer of Guarantee

Patient hereby acknowledges the practice of medicine is not an exact science and that diagnosis and treatment may involve risks and injury and adverse results. Patient hereby acknowledges that no guarantees have been made to the Patient or those acting for Patient as the results of procedures which Patient may undergo while a patient of CGHVC.

3. Acknowledgments of Patient

Patient understands that:

a. It is customary, absent emergency or extraordinary circumstances, that no substantial or invasive procedures be performed upon a patient unless and until the patient has had the opportunity to discuss these procedures with the physician or other health professional so that the Patient may be informed of the contemplated procedures.

b. Each patient has the right to consent, or refuse to consent to any specific procedures or therapeutic course of treatment. If Patient refuses consent to the administration of blood or blood products, CGHVC reserves the right to decline to provide medical care if, in the opinion of the Attending Physician, the refusal of blood products possesses a serious threat to Patient.

4. Patient Understanding of Consent

This consent form has been adequately and fully explained to Patient, and Patient, by his or her signature, indicates satisfaction as to an adequate understanding of this consent and of its significance and that Patient is voluntarily executing the same.

5. Assignment of Insurance Benefits

For value received, I hereby irrevocably transfer, assign, and set over to CGHVC all insurance benefits of every kind and description, which benefits would be payable directly to me except for this assignment, and not to exceed CGHVC's regular charges for the medical care given me. CGHVC receives the right not to accept assignment of such benefits at its discretion.

6. Validity of Consent

This consent is valid during the entire term of my association with CGHVC and may be relied upon by CGHVC unless, and until, revoked by Patient in writing.

7. Notice of Privacy Practices and Notice of Individual Rights

I acknowledge by signing below that I have reviewed the Notice of Privacy Practices and Notice of Individual Rights. Notices available on website.

Signature of Patient _____ Date_____

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA (45 CFR 164.508)

Patient Name	Date of Birth	Medical Record Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In accordance with Georgia State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2), and this re-disclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record form (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Include: *(Indicate by Initialing)*

☐ Other: _____ _____ **Alcohol/Drug Treatment**

_____ _____ **Mental Health Information**

_____ **HIV-Related Information**

_____ **Genetic Testing**

Authorization to Discuss Health Information

(b). ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider to discuss my health information with my attorney, or governmental agency, listed here:

(Attorney/Firm or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ _____

Signature of Patient or representative authorized by law — Date

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PATIENT REVIEW OF SYSTEMS

Name_____ Date _____DOB _____ / _____ / _____

Please circle all symptoms you have had since your last appointment.
(For NEW Patients, list ANY symptoms you have been having.)

General: fever, fatigue, unusual weight loss, or unusual weight gain

CV: chest pain, chest pressure, swelling, dizziness, passing out, irregular heart beat, fast heart beat, or slow heart beat

RESP: cough, shortness of breath, or coughing up blood

NERO: dizziness, passing out, headaches, or falls

UNDO: sweating, or cold intolerance

GI: nausea, vomiting, diarrehea, heartburn, vomiting blood, dark blood in stools, or bright blood in stool

GU: blood in urine, painful urination, or difficulty urinating

MS: joint pain, muscle pain, or pain in muscles when walking

EYES: blurry vision, or loss of vision

DERM: rash, or itching

PSYCH: anxiety, or depression

HEME: abnormal bruising, or bleeding

ENT: ringing in ears, or nose bleeds

Is there anything else you would like to talk about with your provider today?

_____

Patient Signature: _____