PATIENT INFORMATION SHEET

CARDIOVASCULAR INSTITUTE
OF NORTHWEST FLORIDA

PATIENT'S NAME (LAST): _____

(FIRST):_____ DOB: _____

MARITAL STATUS:_____ SOCIAL SECURITY #: _____-_____-_____ SEX: Male ____ Female ____

RACE: ___ AFRICAN AMERICAN ___ ASIAN ___ CAUCASIAN ___ OTHER

LANGUAGE: ___ ENGLISH ___ FRENCH ___ SPANISH

ETHNICITY: ___ HISPANIC OR LATINO ___ NOT HISPANIC OR LATINO ____ REFUSED TO ANSWER

EMAIL: (IF YOU DO NOT HAVE ONE PLEASE INDICATE "NONE") _____

MAILING ADDRESS: (IS THE ADDRESS ON YOUR PHOTO ID CORRECT? ___ YES ___ NO (IF NOT PLEASE UPDATE BELOW)

_____
Street # City State Zip

HOME NUMBER: (____) _____-_____ CELL PHONE: (____) _____-_____ WORK NUMBER: (____) _____-_____

RESPONSIBLE PARTY: (IF DIFFERENT THAN PATIENT)

RELATION TO PATIENT: ____PARENT ____ OTHER

FIRST NAME: _____ LAST NAME: _____

HOME PHONE: _____ CELL PHONE: _____

DO YOU AGREE TO RECEIVE VOICE MAIL MESSAGES REGARDING APPOINTMENTS OR FROM THE NURSE? ___ YES ___ NO

NAME AND CITY OF YOUR PHARMACY: _____

DO YOU GIVE CONSENT FOR US TO RUN PRESCRIPTION ELIGIBILITY FOR YOU: ___ YES ___ NO

DO YOU HAVE A LIVING WILL? YES _____ NO _____

INSURANCE INFORMATION

I authorize Cardiovascular Institute of Northwest Florida to file my insurance and accept payment for services rendered.

Patient Signature: _____Date: _____

Name of Primary Insurance: _____ Policy/Member #:_____

Group #:_____ Policy Holder/Subscriber Name: _____

DOB: ____/____/_____ Sex: _____ Relationship to Patient: _____

Name of Secondary Insurance: _____ Policy/Member #:_____

Group #:_____ Policy Holder/Subscriber Name: _____

DOB: ____/____/_____ Sex: _____ Relationship to Patient: _____

Please complete the following portion if you would like for us to be able to discuss your Cardiovascular Institute of NW Florida medical or billing information with another person of your choosing.

I AUTHORIZE THE PHYSICIANS AND STAFF OF CARDIOVASCULAR INSTITUTE OF NW FLORIDA TO DISCUSS OR RELEASE MY MEDICAL RECORDS, CLINICAL INFORMATION AND OR BILLING INFORMATION WITH THE FOLLOWING INDIVIDUAL:

Name: _____Phone #: _____ Relationship to Patient: _____

Name: _____Phone#: _____ Relationship to Patient: _____

SIGNATURE OF PATIENT_____ DATE_____

(This authorization will remain in effect until it is revoked in writing and may be revoked in writing at any time.)

CARDIOVASCULAR INSTITUTE
OF NORTHWEST FLORIDA

(850)769-0329
625 W. Baldwin Rd., Suite C
Panama City, FL 32405

DATE: _____ /_____ / _____

Patient Name	Date of Birth	Age	Marital Status (circle one)
			Single Married Divorced Widowed

REASON FOR TODAY'S APPOINTMENT: _____

_____

WHO REFERRED YOU FOR TODAY'S APPOINTMENT? _____

WHO IS YOUR PRIMARY DOCTOR? _____

MEDICAL CONDITIONS		PAST SURGERIES
1)	6)	1)
2)	7)	2)
3)	8)	3)
4)	9)	4)
5)	10)	5)

FAMILY HISTORY					MEDICATIONS
	If Living		If Deceased		1)
	Age	Health	Age	Cause of Death	2)
Father					3)
Mother					4)
Brothers or Sisters:					5)
1)					6)
2)					7)
3)					8)
4)					9)

Allergies: _____

Are you allergic to IVP Dye? Yes or No Are you allergic to Latex? Yes or No

SOCIAL HISTORY

Occupation: _____ Occupation of Spouse: _____

Birthplace: _____ Hobbies You Enjoy: _____

Have you ever smoked? Yes or No How much? _____ For how long? _____

When did you quit smoking? _____

Do you drink alcohol? Yes or No How much/how frequently? _____

Do you exercise? Yes or No How much / how frequently? _____

PATIENT NAME: _____ DATE: _____

PLEASE CIRCLE IF ANY OF THESE SYMPTOMS ARE PRESENT:

CONSTITUTIONAL: Fever, chills, weakness, sweats, weight gain, weight loss, loss of appetite

ALLERGY: IVP Dye

EYES: Sudden loss of vision in one or both eyes, blurred vision, discharge, itching, pain, redness

EARS: pain, bleeding, drainage, hearing loss

NOSE: bleeding, discharge

THROAT: pain, swelling, voice change, difficulty swallowing

CARDIAC: black out spells, fainting spells, heart racing, heart skipping beats, chest pain, difficulty laying flat due to breathing problems, dizziness

PULMONARY: Shortness of breath, history of COPD, history of asthma, wheezing, coughing up blood, pain with breathing

GI: history of ulcers, hiatal hernia, diverticulitis, blood in stool or unusually dark stools, history of liver problems, hepatitis, cirrhosis, abdominal pain, nausea, vomiting

GU: history of kidney disease, blood in urine, painful urination

MUSCULOSKELETAL: Aching in muscles of calves, legs or buttocks when walking

SKIN: Loss of hair on legs, rash, itching

NEUROLOGIC: history of stroke, history of seizures, headache, problems when walking

PSYCHIATRIC: history of anxiety, history of depression

ENDOCRINE: history of diabetes: if so, when were you diagnosed? _____
History of thyroid disease

PREGNANCY: Are you pregnant? _____ Do you plan to get pregnant in the future? _____

HEMATOLOGIC: Easy bruising, abnormal bleeding, history of blood clots

Are you a FORMER or a CURRENT smoker?

Have you ever had a CT Scan or ultrasound of the abdomen checking for aneurysm?

Cardiovascular Institute of Northwest Florida
Notice of Privacy Practices

This notice describes how private health information ("PHI") about you may be used and disclosed and how you can get access to this information. ***Please review it carefully.***

I. We are required by law to:

- Make sure your PHI is kept private.
- Give you this notice outlining our duties and practices regarding your PHI ***and*** comply with the terms of this notice.
- Disclose your PHI only as described in this notice, unless we obtain your written consent.
- Promptly notify you if a breach occurs that may have compromised the privacy of your PHI.

II. The following describes the ways in which we may use or disclose your information:

- **Treatment**: We may use health information about you to provide you with treatment or services. We may also disclose health information about you to other medical providers who are involved with your health care.
- **Billing or Payment**: We may use and disclose information about treatments and services for billing purposes. This includes disclosure to health plans, insurance companies or other entities.
- **Practice Operations:** We may use your information to run our practice, improve your care, or to contact you as necessary, including appointment reminders.
- **Lawsuits or Legal Action:** If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court order, administration order, or subpoena.
- **Compliance with the Law:** We may share your information, if federal, state, or local law requires it.
- **Public Health and Safety:** We may share your information in certain situations, such as disease prevention, product recalls, adverse reactions to medications, to report abuse, neglect, or domestic violence, or to prevent a serious threat to anyone's health or safety.
- **Other:** Your information may be shared for purposes related to workers compensation, governmental or military related requests, or health research purposes.

III. Your rights:

- You may inspect and/or obtain a copy of your health information, including billing statements. Upon your written request, a copy will be provided to you, usually within 30 days. You may be charged a cost-based fee to fulfill your request.
- If you believe that your health information is incorrect or incomplete, you may ask us to review or amend the information. We will respond to your written request to do so, usually within 60 days.
- You may request that we restrict or limit how we use or communicate your health information, and we will comply with all reasonable requests. We are not required to agree to your request, if we believe it will affect your care or if the law requires otherwise.
- You may request a list of whom we have shared your PHI for 6 years prior to your written request. This list will not include disclosures for the reasons outlined in ***Section II*** of this notice.
- You may request that we contact you regarding your health using a specific phone number or address. We will make effort to honor your request.
- You may assign legal rights to someone to act or make health care related decisions on your behalf, and we will ensure we have written proof of such legal rights before taking action.

We consider the privacy of your health information a very serious and important matter. If you believe your privacy rights have been violated, you may file a complaint with us by contacting our HIPAA Privacy Officer by phone at **850-769-0329** or by mail at **625 W. Baldwin Rd., Suite C, Panama City, FL 32405.** You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights in Washington, D.C. , by phone at 877-696-6775 or by visiting *www.hhs.gov/ocr/privacy/hipaa/complaints/*

By signing the consent on your Patient Information form, you are acknowledging that you have received, read, and understand the information provided in this notice.