NORTH TEXAS
COMPREHENSIVE CARDIOLOGY

PATIENT INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status: Single / Mar / Div / Sep / Wid

Ethnicity : ❑ Declined ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Unknown	Race : ❑ Declined ❑ American Indian ❑ Asian ❑ White ❑ Black or African American ❑ Native Hawaiian	Social Security #:	Date of Birth: / /	Age:	Sex: ❑ M ❑ F

Primary Language : _____	Primary Care Physician /Referring Doctor's Name: _____
Mailing Address:	PRIMARY Phone # ( ) / Secondary Phone # ( )

City:	State:	Zip Code:	Email Address:
Occupation:	Employer:		Work Phone # ( )

Preferred Pharmacy (Please include name & address):

❑ Local Pharmacy: _____

❑ Mail Order Pharmacy: _____

INSURANCE INFORMATION

Primary Insurance Carrier	*Group Number:*	*Birth Date:*
Member ID #	*Who is the insured?*	*Relationship to the Insured*
Secondary Insurance Carrier:	*Group Number*	*Birth Date:*
Member ID #	*Group Number*	*Birth Date:*

GUARANTOR / RESPONSIBLE PARTY		

IN CASE OF EMERGENCY		
Name of friend or relative:	Relationship to patient:	Home Phone: Cell Phone:

This information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ***North TX Comprehensive Cardiology*** *or insurance company to release any information required to process my claims.*

Patient/Guardian Signature: **Date:**

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name:_____

Address: _____

Date of Birth:_____ Social Security Number: _____

Authorizes North TX Comprehensive Cardiology to release the following medical information to:

Name of Person (family member, caregiver, etc.) _____

Address: _____

City/State/Zip_____ Phone Number: _____

□ Confer orally with person(s) listed below about my medical conditions: (family member, caregiver, etc.)

Name of Person: _____

May we contact you at work and/or leave a message? □ Yes □ No

May we contact you at home and/or leave a message regarding appointments? □ Yes □ No

This authorization shall be valid from the date of signature. The patient can revoke this authorization in writing at any time.

The patient agrees that a photocopy of this authorization may be considered valid. □ Yes □ No

_____ _____

Signature of Patient or Representative Relationship to Patient

_____ _____

Date Signed Witness Signature

Office Policies

Patient Name: _____ **Date of birth:** _____

As a patient of North TX Comprehensive Cardiology I understand that the following policies are currently in effect:

- A $30.00 fee will be assessed on all returned checks. Returned checks will have to be paid in cash within 10 days of notification. I also understand if outstanding check is not resolved within the 10 day limit I may be dismissed from the practice.

- I understand payment is due at time services are rendered, unless prior payment arrangements are made with the office. This includes any deductible, copayment or co-insurance amounts. Any balances not paid by my insurance carrier are my responsibility to resolve. I further understand that balances due must be paid in a timely manner to avoid further collection action. I understand if my account is forwarded to a collection agency I may be dismissed from the practice, my outstanding balance may be reported to the credit bureau and my balance may be charged an 18% interest rate per year until balance is resolved.

- **I am to present proof of my insurance coverage at *every* office visit**.

- **NO SHOWS**- If you do not show up to 3 or more consecutive appointments, we will **NOT** schedule anymore appointments and you will be dismissed from our practice.

- **Finally, I understand that I am to allow at least 48 hours for my prescription refills**.

My signature confirms I have read & understood the above office policies and have had an opportunity to ask questions regarding any concerns I may have about these policies.

_____ _____

Patient Signature **Date**

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize NTCC to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of NTCC

I have also been informed of and given the right to review and secure a copy of the clinic's *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that NTCC reserves the right to change the terms of this notice from time to time and that I may contact them at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that NTCC is not required to agree to these requested restrictions. However, if they do agree, they are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name

_____

Relationship to Patient

Dr. David Davis
Dr. Nikhil Joshi/ Dr. M. Taimoor Gill

Patient Health Questionnaire

NAME: _____ **DATE**: _____

Please answer the following questions to the best of your ability. This will help your doctor know more about you. These answers, of course, are confidential.

Marital Status (Married,Single,Divorced,Widowed) _____

Do you have children? ☐ Yes ☐ No If So, How Many? _____

Your Preferred Language is: _____

Your Race/Ethnicity is: _____

Are you retired? ☐ Yes ☐ No

If retired, what type of work did you do? _____

If currently employed, what type of work do you do? _____

Do you smoke? ☐ Yes ☐ No, but used to ☐ Never

If you used to smoke, when did you quit? _____

How many packs of cigarettes do you or did you smoke and for how many years?

(Example: 1 pack/day for 20 years) _____

Do you drink alcohol? ☐ Yes ☐ No, but used to ☐ Never

If you used to drink, when did you quit? _____

How much do you or did you drink in an average week?

☐ 0-1 drinks or beers/week, ☐ 1-5, ☐ 6-10, ☐ more than 10

Do you have a history of Drug Use/Abuse? ☐ Yes ☐ No

Are you following any special diet? ☐ Yes ☐ No If yes, please specify:
_____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, list please:_____

Are you allergic to iodine, shrimp, or shellfish? ☐ Yes ☐ No

Have you ever received x-ray contrast in your vein for any reason (myelogram, kidney series, CAT scan, etc.)?

☐ Yes ☐ No If yes, did you have a problem with this? _____

Have you had a blood transfusion? ☐ Yes ☐ No If so, When? _____

Have you had any operations or surgeries in the past? ☐ Yes ☐ No

If yes, what type and approximate date _____

Please list all medications (prescription and non-prescription) you are supposed to be taking at home (see example).

	NAME	DOSE/STRENGTH	NUMBER TAKEN AT TIME OF DAY
EXAMPLE:	**Lasix**	**40mg.**	**2 at 9 a.m., 1 at 6:00 p.m.**
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____

Family medical history:

Father's age _____, or age at death _____ cause of death _____.

Mother's age _____, or age at death _____ cause of death _____.

Sibling, (brother or sister), age, or age at death:

1) _____, _____ age, _____ age at death
2) _____, _____ age, _____ age at death
3) _____, _____ age, _____ age at death
4) _____, _____ age, _____ age at death
5) _____, _____ age, _____ age at death

Medical Problems	**Father**	**Mother**	**Sibling (s)**
1) Heart attack	_____	_____	_____
2) Stroke	_____	_____	_____
3) Diabetes	_____	_____	_____
4) High blood pressure	_____	_____	_____
5) Angina	_____	_____	_____

Other family members with heart problems:
(Example: Paternal uncle, age 55, has a pacemaker.)

_____

_____

_____

_____

_____

_____

Please answer the following questions that relate to health problems that <u>you</u> currently have or have had in the past. Please use a check mark under the "YES" or "NO" column.

	YES	NO
Headaches		
Fatigue or Weakness		
Blurred vision / Double vision/ Eye pain (circle all that apply)		
Sore throat / Dry mouth (circle all that apply)		
Weight Loss / Weight Gain		
Heat Intolerance / Cold Intolerance		
Coughing blood		
Cough / Wheeze / Asthma (circle all that apply)		
Emphysema or COPD (circle all that apply)		
Chest Pain		
Palpitations or Arrhythmia		
Nausea or Vomiting (circle one)		
Diarrhea or Constipation (circle one)		
Abdominal pain / Heart burn (circle all that apply)		
Abnormal bleeding or Bruising		
Blood in urine / difficulty urinating (circle all that apply)		
Back pain / Muscle Weakness / (circle all that apply)		
Arthritis		
Skin hives / Abnormal skin rash (circle all that apply)		
Syncope / Passing out Episodes		
Numbness		
Seizures		
Dizziness		
Stress / Anxiety / Depression (circle all that apply)		
Swelling in Legs / Edema		
Diabetes		
Thyroid Disease		
High Cholesterol		
History of Rheumatic Fever		