WELCOME!

All the staff at Florida Heart and Vascular Center would like to take this time to extend a heartfelt welcome to you as a new patient to our practice. We look forward to providing you with the best cardiac care and trained technical staff Florida has to offer. We provide both cardiovascular and peripheral vascular treatment plans using the most sophisticated medical equipment in the area.

Enclosed you will find many papers to fill out which will help expedite your visit with us. It will save you time and you will be able to better fill out these pages in the comfort of your home rather than waiting until the day you come to the office for your first appointment.

Remember these important things on each visit to our office:

♥ Bring ALL your medications in a bag to EACH visit.
♥ Sign the enclosed “Record Release” form for us to obtain previous records for your cardiac care, especially surgical reports.
♥ On EACH visit keep us updated on studies/surgeries you have had since we last saw you, especially if you travel north, try to bring copies of your studies back with you or have them mailed to us.
♥ Feel free to call with any questions you may have. We will always do our best to get you the information you need.
♥ Visit our website www.flheartcenter.com for more information.

Upon checking into Florida Heart and Vascular Multi-Specialty Group as a new patient you will be provided with a Health Card. Your Health Card will include physician information, allergies, and contact information regarding Florida Heart and Vascular Multi-Specialty Group. Please keep the Health Card with your insurance cards in your wallet. When checking out you will also receive a card that includes all medications that will be updated as necessary. If at any time you require a hospital admission, please present these cards to them, so they can contact us for a consultation.

Once again, WELCOME to Florida Heart & Vascular Center. We look forward to your visit with us.

Florida Heart & Vascular Center
Physicians and Staff
Medical Release Authorization

Patient Name: ___________________________    DOB: _____ / _____ / _____

I hereby authorize and request __________________________ to release medical information concerning my medical care to Florida Heart and Vascular Multi-Specialty Group, for the purpose of ____________________________

(Specific purpose of disclosure of record)

The type and amount of information to be disclosed is as follows: (Specify dates where appropriate)

- History & Physical
- Discharge Summary
- Lab Results
- EKG(s)
- Cardiac Catheterization Report(s)
- Cardiac Catheterization Images
- Echocardiogram Report(s)
- Cardiac Catheterization Images
- Chest X-Ray Report(s)
- Abdominal Ultrasound Report(s)
- Carotid Ultrasound Report(s)
- Peripheral Ultrasound Report(s)
- Peripheral Angiogram Report(s)
- Peripheral Angiogram Images
- Most Recent Office Notes
- Other
- Stress Test Report(s)
- Peripheral Angiogram Images

I understand that the information may include the release of information concerning HIV testing or treatments of AIDS or AIDS related conditions, drug or alcohol abuse (or related conditions), and mental health conditions.

I understand the use or disclosure of my individual health information, as described above. I understand that this authorization will expire, without my express revocation, either one (1) year from the date of signing, or if I am a minor, on the date I become an adult according to state law, which ever occurs first. I understand that authorization for the disclosure of this health information is voluntary, and I can refuse to sign this authorization. I understand that this authorization is revocable, upon written notice to the office where the original authorization is retained.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulation, and that it may be re-disclosed by the recipient.

The facility, its employees, officers, and physicians are hereby released from any liability for the disclosure of the above information to the extent indicated and authorized therein.

________________________________________  /   /   
Patient Signature                              Date

Signature of Parent or Legal Representative

Please Fax Records to (352)728-1743
Authorization for Disclosure of Health Information

Many of our patients allow family members, such as their spouse, significant other, parents, and/or children to call and request results of tests, procedures, and financial information. Under the requirements of H.I.P.A.A., we are not permitted to give any of this information to anyone without the patient’s written consent. If you wish to have your medical information, diagnostic test results, and/or financial information released to any individuals/family members, you must sign this form. The facility, its employees and physicians, are hereby released from any liability for the disclosure of information released therein. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Florida Heart and Vascular Multi-Specialty Group to release any or all information concerning my medical care to the following individuals:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Patient</th>
<th>Phone Number</th>
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<tbody>
<tr>
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</tbody>
</table>

I authorize Florida Heart and Vascular to leave normal test results on my answering machine or voicemail.

Patient Name (PRINT) / / SSN

Patient Signature / / Date

Witness Signature / / Date
**TODAY'S DATE____________ PLEASE PRINT- USE BLACK OR BLUE INK ONLY**

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE INITIAL</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
</table>

**HOME STREET ADDRESS | CITY | STATE | ZIP**

**HOME PHONE | CELL PHONE | WORK PHONE**

( ) ( ) ( )

**SECONDARY HOME STREET ADDRESS | CITY | STATE | ZIP**

**SEX | SOCIAL SECURITY NO. | MARITAL STATUS**

□ M □ F

**EMAIL ADDRESS | DO YOU HAVE A LIVING WILL? | IF YES, PLEASE PROVIDE A COPY FOR YOUR MEDICAL FILE**

**EMPLOYER’S NAME | STREET ADDRESS | CITY | STATE | ZIP**

**HOW MANY INSURANCE PLANS? | ARE YOU RESPONSIBLE FOR FEES? | PRIMARY INSURANCE & POLICY ID | PRIMARY INSURANCE POLICY HOLDER**

□ YES □ NO □ OTHER WHO?

**SECONDARY INSURANCE & POLICY ID | SECONDARY INSURANCE POLICY HOLDER**

**EMERGENCY CONTACT LAST NAME | FIRST NAME | MIDDLE INITIAL | DATE OF BIRTH | PHONE | RELATIONSHIP**

**PRIMARY CARE PHYSICIAN & PHONE NUMBER**

It is the policy of FLORIDA HEART & VASCULAR MULTI-SPECIALTY GROUP to release information to your immediate family and/or leave messages with them or on your answering machine regarding: appointments, lab/tests results, billing, or any other information we feel is necessary to provide quality care for you, unless otherwise stated by you in writing.

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I Have Read, The Health Insurance Portability & Accountability Act of 1996 (HIPAA), and understand my rights.

(Purple Sheet)

X__________________________ Date__/__/____

(Should you desire a copy of this form, please advise the front receptionist.)

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**PLEASE GIVE INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST TO COPY FOR YOUR FILE.**

**CONSENT FOR TREATMENT AND LIFETIME AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE**

I hereby give consent to FLORIDA HEART & VASCULAR MULTI-SPECIALTY GROUP to provide whatever treatment they may deem necessary to the patient above.

I understand that I am responsible for charges incurred for services. I understand I am responsible for charges not covered by the insurance policy or Medicare, and should it become necessary to collect these charges through an attorney for other collection process, I shall be responsible for all court costs, interest, collection costs, and attorneys fees.

I hereby request payment of authorized Medicare benefits and/or any other including supplemental insurance benefits for me to be paid directly to FLORIDA HEART & VASCULAR MULTI-SPECIALTY GROUP for any services furnished me by FLORIDA HEART & VASCULAR MULTI-SPECIALTY GROUP. I authorize FLORIDA HEART & VASCULAR MULTI-SPECIALTY GROUP and staff to release to my insurance carrier and its agents any information concerning health care, advice, treatment or supplies provided me, needed to determine these benefits payable for related services. I understand this is a lifetime authorization.
# COMPLETE HISTORY & PHYSICAL RECORD

**Date** _________________________

**Name** ____________________________  **Sex/Race** _________  **Age** ____________

**Occupation** _________________________ (If retired previous occupation)

**Present Illness** ___________________________________________________________

**Allergies:** _______________________________________________________________

**Previous Surgeries and date:** ______________________________________________

________________________________________

________________________________________

**Past Medical History—(Please check if you have had these).**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>High Blood Pressure</td>
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<td></td>
<td></td>
<td>Arthritis</td>
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<td></td>
<td></td>
<td>Diabetes</td>
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<td></td>
<td></td>
<td>Pneumonia</td>
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<td></td>
<td></td>
<td>High Cholesterol</td>
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<tr>
<td></td>
<td></td>
<td>Bleeding Disorder</td>
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<tr>
<td></td>
<td></td>
<td>Heart Disease</td>
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<tr>
<td></td>
<td></td>
<td>Cancer</td>
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<td></td>
<td></td>
<td>Heart Attack</td>
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<td></td>
<td></td>
<td>Radiation Treatment</td>
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<tr>
<td></td>
<td></td>
<td>Congestive Heart Failure</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Tuberculosis</td>
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<tr>
<td></td>
<td></td>
<td>Palpitations (rapid Heart Beat)</td>
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<td></td>
<td></td>
<td>Epilepsy</td>
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<td></td>
<td></td>
<td>Fainting</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Cataracts</td>
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<td></td>
<td></td>
<td>Dizziness</td>
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<tr>
<td></td>
<td></td>
<td>Respiratory Arrest</td>
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<td></td>
<td></td>
<td>Thyroid Disease</td>
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<td></td>
<td></td>
<td>Abdominal Aortic</td>
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<td></td>
<td></td>
<td>Rheumatic Fever</td>
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<td></td>
<td></td>
<td>Aneurysm</td>
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<td></td>
<td></td>
<td>Stroke/mini strokes</td>
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<td></td>
<td></td>
<td>Cardiac Arrest</td>
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<td></td>
<td></td>
<td>Asthma/Emphysema</td>
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<td></td>
<td></td>
<td>Hiatal Hernia</td>
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<td></td>
<td></td>
<td>Nervous Condition</td>
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<tr>
<td></td>
<td></td>
<td>Liver Disease</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Kidney Disease</td>
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<tr>
<td></td>
<td></td>
<td>Anemia</td>
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<tr>
<td></td>
<td></td>
<td>Kidney Stones</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Bladder Infections</td>
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<tr>
<td></td>
<td></td>
<td>Peptic Ulcer</td>
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<td></td>
<td></td>
<td>Gout</td>
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<tr>
<td></td>
<td></td>
<td>Gall Bladder Disease</td>
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</tr>
</tbody>
</table>

**Pharmacy and Phone Number**  __________________________________________
All Physicians that you are currently under the care of

<table>
<thead>
<tr>
<th>Physician, Specialty</th>
<th>Office phone number</th>
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<tbody>
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</tbody>
</table>

Do you have or have you had within the past year:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fainting spells</td>
<td></td>
<td></td>
<td>Purple lips or fingers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness when changing positions</td>
<td></td>
<td></td>
<td>Palpitations or fluttering of heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unconscious spells</td>
<td></td>
<td></td>
<td>High blood pressure</td>
<td></td>
<td></td>
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<tr>
<td>Chest pain</td>
<td></td>
<td></td>
<td>Leg cramps when walking</td>
<td></td>
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<tr>
<td>Angina</td>
<td></td>
<td></td>
<td>or at night</td>
<td></td>
<td></td>
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<tr>
<td>Pain in arm(s)</td>
<td></td>
<td></td>
<td>Recurrent stomach pain</td>
<td></td>
<td></td>
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<tr>
<td>Pain in jaw</td>
<td></td>
<td></td>
<td>Belching or heartburn</td>
<td></td>
<td></td>
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<tr>
<td>Coughed up blood</td>
<td></td>
<td></td>
<td>Relieved by food or</td>
<td></td>
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<tr>
<td>Chronic or frequent cough while lying down</td>
<td></td>
<td></td>
<td>medication</td>
<td></td>
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<tr>
<td>Wake up at night</td>
<td></td>
<td></td>
<td>Nausea or vomiting</td>
<td></td>
<td></td>
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<tr>
<td>Short of breath</td>
<td></td>
<td></td>
<td>Vomited blood</td>
<td></td>
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<tr>
<td>Shortness of breath when movement</td>
<td></td>
<td></td>
<td>Any blood in bowel</td>
<td></td>
<td></td>
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<tr>
<td>Walking several blocks</td>
<td></td>
<td></td>
<td>Tiredness without</td>
<td></td>
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<tr>
<td>One flight of stairs</td>
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<td></td>
<td>apparent reason</td>
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<tr>
<td>When lying down</td>
<td></td>
<td></td>
<td>Night sweats</td>
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</tbody>
</table>

How many pillows do you use? ________
Swelling of hands, feet or ankles? ________
At what time of day? ________________
Diagnostic tests (check if have had and when) _______________________________________
Electrocardiogram (EKG)
Stress test
Echocardiogram (ultra sound of heart)
Holter monitor
Permanent pacemaker
A.I.C.D. (Automatic Implantable Cardioverter Defibrillator)
Have you ever been on a respirator (Breathing machine)? ________
How long? ________________
Cardioversion (electric shock delivered to heart to convert irregular heartbeat) ________________
Cardiac arrest (Heart completely stops beating and required electric shock to heart or CPR to correct) ________________
P.T.C.A. (Balloon Angioplasty of any heart arteries)
Cardiac Catherization Date: ________________ What Hospital ________________________
Results ____________________________________
Do you use oxygen at home? _________ How many liters? _______ How many times per day? _______
Do you use tobacco? _______ Amount ___________ How long __________
Quit? (when) _______ How long did you smoke/chew? __________________
Alcohol ___________ Caffeine _______________
Number of pregnancies ___________ Number of children born alive ___________
Number of cesarean section deliveries ___________
Marital status ________________
Medication: List name, dose, and the amount taken each day ______________________________

<table>
<thead>
<tr>
<th>Family Information</th>
<th>Age</th>
<th>Health</th>
<th>Age at Death</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mother</td>
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</tr>
<tr>
<td>Siblings</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
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</tbody>
</table>

Please check if a blood relative has ever had any of the following and indicate who.

<table>
<thead>
<tr>
<th>Heart disease</th>
<th>NO</th>
<th>YES</th>
<th>Thyroid disease</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>NO</td>
<td>YES</td>
<td>Diabetes</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>NO</td>
<td>YES</td>
<td>High Cholesterol/Triglyceride</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>