Florida Heart & Vascular
Multi-Specialty Group

Experience Our Integrity and Compassionate Care

Primary Care

Cardiology

David C. Lew, MD, FACC, FSCAI
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Bosede A. Afolabi, MD, FHRS

Surgery

David Sustarsic, MD, FACS
General & Vascular
Nessa E. Miller, MD, RPVI
Vascular

Family Practice

Jeffrey Robinson, MD, FAAFP, CAQG
Larry D. Foster, MD, FAAFP, CAQG
Kenneth Obiaja, MD, MPH, FAAFP
Maria Bello, MD, MPH
Tanya Diaz, MD, FAAFP
Michael McGinnity, PA

Debbie Pate, ARNP, ANP-C
Tara Brannen, ARNP

Internal Medicine

Fredric Davis, DO
Robert Swietarski, MD, FACP
Florian Gegaj, MD
Michael Glick, MD

Dermatology

Michael Frasure, MSN, ARNP-BC

Nephrology

Romita Mukerjee, MD, MHS

Hospitalist

Alejandro A. Victoria, MD

Dear Patient,

Our goal is to provide you with the most comprehensive health care possible. Please read the information below and let us know if you have any questions. We would like to make your appointment a productive time.

Prescriptions:
We will give you all of your prescriptions at the time of your appointment. Please be prepared with all your needs when you are in the office. Telephone calls are **not** the most effective way to prescribe medication. You will get enough refills to last until your next appointment and one month extra in case you need to reschedule your appointment.

Results:
Laboratory results and diagnostic testing are important methods of evaluation in today's medicine; we will discuss the results at a follow up appointment. This will give you an opportunity to ask questions, become familiar with the meaning of the testing, discuss therapies, and plan the next step. Please make sure you schedule a follow up appointment. If your results are abnormal we will call you as soon as we get the report, **ONLY IF IT IS ABNORMAL.** Otherwise, take the opportunity to discuss all testing at your follow up appointments.

After hour calls:
If you have a life threatening complaint, such as chest pain, shortness of breath, or signs of a stroke, please do not waste precious time calling, go to the ER. We cannot diagnose or prescribe medications after hours. We can only advise you if you can wait until the next business day; if you cannot, you need to go to the ER.

Health Cards:
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.

Thank You for choosing Florida Heart & Vascular Multi-Specialty Group as your healthcare provider!

511 Medical Plaza Drive, Suite 101, Leesburg, FL 34748
(352) 728-6808 • Fax: (352) 728-1743
www.flheartcenter.com

Below you can review the different types of visits we offer.

It is very important you come prepared for your type of visit. If you have other needs, let the medical assistant know so we can prioritize and plan your care accordingly.

Acute care visit: this is a sick visit. A short period of time is scheduled for your urgent need. If you have other needs, you may be asked to schedule a different appointment to address this non urgent need. Always let the medical assistant know all your needs.

Physicals or Health maintenance examination: this is a routine exam that varies according to age and gender. These usually include a vaccination update, screening tests for some types of cancer and cholesterol, or other blood testing if indicated. Medicare only covers one physical exam within one year of when your benefits first become effective. Some commercial insurances provide a "physical" as part of their benefits. If you need your visit to be billed as a physical, please let us know. If you have other needs beside a "physical", you may be asked to schedule a different appointment.

Chronic Disease management: If you suffer from Hypertension (high blood pressure), Diabetes (high blood sugar), Hyperlipidemia (High Cholesterol), Osteoarthritis, or any other condition that requires prescription medication, you will need an appointment at least every 6 months. At this time the chronic condition will be evaluated for appropriate control and or progression as well as side effects of the medications you take. If your chronic condition is NOT controlled, the frequency of your appointment will go to 6 weeks or 3 months until controlled. If you have an appointment for chronic disease management but have another concern or need, you may be asked to schedule a different appointment.

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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)

_____Last 3 Progress Notes
_____Most Recent Laboratory Tests
_____Bone Density
_____Most Recent Radio-Diagnostics Test
_____Problem List / Medication List
_____Other

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

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request results of tests, procedures, financial information. Under the requirements of H.I.P.A.A. we are not allowed to give any of this information to anyone without the patient's consent. If you wish to have your medical information, any 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 the 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 & Vascular Multi-Specialty Group to release any or all information concerning my medical care to the following individuals.

Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone

Patient Name (Print)	Date of Birth	Social Security #

Patient Signature _____ Date _____

Witness Signature _____ Date _____

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PLEASE PRINT- USE BLACK OR BLUE INK ONLY

TODAY'S DATE_____

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
HOME STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE ( )	CELL PHONE ( )	WORK PHONE ( )	
SECONDARY HOME STREET ADDRESS	CITY	STATE	ZIP
SEX ☐ M ☐ F	SOCIAL SECURITY NO.	MARITAL STATUS	
EMAIL ADDRESS	DO YOU HAVE A LIVING WILL? ☐ YES ☐ NO	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? ☐ YES ☐ NO ☐ OTHER WHO?_____		
PRIMARY INSURANCE & POLICY ID	PRIMARY INSURANCE POLICY HOLDER		
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			

POLICY

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.

HIPAA

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.)

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.

Signature of Patient Authorization Date

Signature of Responsible Person Date

ADULT MEDICAL HISTORY QUESTIONNAIRE

To be completed at initial establishment visit and yearly thereafter

Patient Name: _____

Today's date: _____ Allergies: _____

What is the main reason you came here today? _____

How did you hear about us? _____

REVIEW OF SYSTEMS Please check **Yes** or **No** for problems that apply to you at the present time.

General	**YES**	**NO**
Normal activity level		
Changes in appetite		
Weight gain		
Weigh loss		
Chills		
Fever		
Skin		
Rashes		
Sores		
Blisters		
Growth		
Changing moles		
Non healing lesions		
Breast		
Masses		
Discharge		
Skin changes		
Eyes/ears/nose/mouth/throat		
Problems with vision		
Eye pain		
Hearing difficulties		
Tinnitus		
Vertigo		
Hoarseness		
Swallowing difficulties		
Heart and Blood vessels		
Chest pain		
Chest pressure		
Palpitations		
How many pillows you use to sleep?		
Cold extremities		
Feet swelling		

Gastro-intestinal	**YES**	**NO**
Abdominal pain		
Heartburn		
Regurgitation		
Indigestion		
Nausea		
Vomiting		
Change on bowel movement		
Change in caliber of stool		
Difficulty swallowing		
Blood in stool		
Joints and Muscle		
Muscle pain		
Joint pain		
Muscle weakness		
Joint stiffness		
Leg cramps		
Pain in legs with walking		
Neuro/Psychological		
Difficulties n motor strength		
Difficulties in gait		
Difficulties in memory		
Difficulties in concentration		
Changes in mood		
Tremors		
Headaches		
Dizziness		
Lung		
Shortness of breath		
Cough		
Wheezing		

Genitourinary	**YES**	**NO**
Urinary frequency		
Urinary urgency		
Urinary incontinence		
Blood in urine		
Pain with urination		
Sexual dysfunction		

Females only

How many children have you had? _____

How many times pregnant? _____

Have you ever had a C-section? _____

When was your last period? _____

Are your periods regular? _____

How many days do they last? _____

Date of last Pap? _____

Results: _____

Do you have any other medical problems?

Males only

( ) enlarged prostate

( ) painful or lumpy testicles

( ) problems with sex

X-RAYS, OTHER TESTS – Please list the last year that any of the following were done.

Tests	Year	Results
_____ Chest X-ray		
_____ Fecal Occult Cards		
_____ Colonoscopy		
_____ Upper Endoscopy		
_____ CT Scan Abdomen		
_____ Mammogram		
_____ DEXA Bone Density		

Other Tests	Year	Results
_____ Cholesterol measurement		
_____ Cardiac Stress Test (Treadmill)		
_____ Heart Catheterization		
_____ Eye examination		
_____ Dental Examination		
_____ Other		

All Physicians that you are currently under the care of

Physician, Specialty	Office phone number

HOSPITAL AND SURGERY – Please list all hospital admissions, and any other surgeries.

Year	Hospital, city and state	Reason for admission or type of surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS – Please list all medicines that you use frequently or every day.
Include prescription medicines, aspirin, antacids, vitamins, etc.

Medication	Dose	Times/day	Refills left	Medication	Dose	Times/day	Refills left
1.				7.			
2.				8.			
3.				9.			
4.				10.			
5.				11.			
6.				12.			

Pharmacy Name: _____ Address: _____
Telephone: _____ Do you need a 90 day prescription? Yes No
Do you need a separate script for each prescription? Yes No

FAMILY HISTORY – Please fill in blanks and check ( ) appropriate items

	Father	Mother	Others	Explain
Colon Cancer				
Breast Cancer				
Other Cancers				
High Blood Pressure				
Heart Problems				
Stroke				
Diabetes				
Kidney Problems				
Osteoporosis				
Sickle Cell				
Seizures, Epilepsy				
Mental Illness				
Depression, Anxiety				
Alcoholism				
Dementia or Alzheimers				

SOCIAL HISTORY – Please circle responses, or fill in blanks

1. What is your usual occupation? _____ What kind of work do you do now? _____
2. What is the highest grade in school you completed? _____
3. Are you? Single Married Divorced Separated Widowed
4. Do you exercise? Never Rarely Once a week 3-4 times/week Type of exercise _____
5. Do you use tobacco? _____ Cigarettes Cigars Pipe Snuff Chewing tobacco How many packs/day? _____
   How many years have you smoked? _____ If you have quit smoking, when? _____
6. Do you use alcohol? _____ In a week, how many cans of beer _____ glasses of wine _____ shots of liquor _____
7. How many cups of coffee, tea, or cola do you drink in a day? _____
8. Do you sometimes use marijuana or other drugs socially? _____
9. Are you sexually active? (men, women, or both) _____
10. Have you ever had a sexually transmitted disease, such as gonorrhea, syphilis, or herpes? _____
11. Have there been any unusual stresses in your life in the last year? _____ Broken relationships? _____ Illness/death in the family?_____
    Change of Job? _____ Moved? _____ Finances? _____
12. Do you use seat belts? _____ Smoke alarms? _____
13. Abuse as a child? _____ Physical (hitting) _____
    Abuse as an adult? _____ Sexual (unwanted advances) _____
    Abuse now? _____ Emotional (yelling, shaming) _____
14. Is there anything special you would like to talk about? _____