



# Florida Heart & Vascular

## Multi-Specialty Group

*Experience Our Integrity and Compassionate Care*

### *Surgery*

#### *Cardiology*

David C. Lew, MD, FACC, FSCAI  
*Chairman*  
Jose R. Rosado, MD, FACC  
*Vice Chairman*  
John R. Hurt, MD, FACC  
Patrick K. Williams, MD, FACC  
Marwan Mihyu, MD, FACC  
Joseph G. Sahab, MD, FACC  
Rajesh Tota-Maharaj, MBBS, FACP  
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

## 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 medical 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](http://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 Multi-Specialty Group



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

[www.flheartcenter.com](http://www.flheartcenter.com)



# Florida Heart & Vascular Multi-Specialty Group

*Experience Our Integrity and Compassionate Care*

511 Medical Plaza Drive, Suite 101  
Leesburg, FL 34748  
(352) 728-6808

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

**Please Fax Records to (352)728-1743**



# Florida Heart & Vascular

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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



# Florida Heart & Vascular

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PLEASE PRINT- USE BLACK OR BLUE INK ONLY

TODAY'S DATE \_\_\_\_\_

<b>PATIENT INFORMATION</b>	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 <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NO.		MARITAL STATUS			
	EMAIL ADDRESS				DO YOU HAVE A LIVING WILL? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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						
<b>POLICY</b>	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.						
<b>HIPAA</b>	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

**HISTORY & PHYSICAL**

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**WEIGHT:** \_\_\_\_\_ **HEIGHT:** \_\_\_\_\_ **BP:** \_\_\_\_\_ **PULSE:** \_\_\_\_\_ **RES:** \_\_\_\_\_

**REFERRING DOCTOR:** \_\_\_\_\_

**ALL DOCTORS WITH WHOM PATIENT HAS ESTABLISHED RELATIONSHIP**

\_\_\_\_\_  
\_\_\_\_\_

**HISTORY OF PRESENT ILLNESS (HPI):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST HOSPITALIZATIONS & SURGERIES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY** [Patient please circle yes (Y) or no (N)]

CONDITION	YES	NO	COMMENTS
High Blood Pressure	Y	N	_____
Respiratory Problems	Y	N	_____
Bleeding Problems	Y	N	_____
Diabetes	Y	N	_____
Stroke	Y	N	_____
HIV/AIDS	Y	N	_____
Heart Trouble	Y	N	_____
Cancer	Y	N	_____
Liver Disease (hepatitis , cirrhosis )	Y	N	_____
Kidney Disease	Y	N	_____
MRSA Infection	Y	N	_____
Sleep Apnea	Y	N	_____
Other Problems	Y	N	_____

Do you or a family member have a history of:

Cancer    yes    no                      Kidney disorders:    yes    no

Cardiovascular disease    yes    no

**GENERAL, THORACIC, AND VASCULAR SURGERY**

*HISTORY & PHYSICAL - TO BE COMPLETED BY PATIENT*

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**CURRENT MEDICATIONS:**


**ALLERGIES:**

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**REVIEW OF SYSTEMS** [Patient please circle yes (Y) or no (N)]

<b>CONSTITUTIONAL</b>	YES	NO	<b>EAR/NOSE/MOUTH/THROAT</b>	YES	NO	<b>EYES</b>	YES	NO
Good General Health	Y	N	Hearing Loss or Ringing	Y	N	Wear Glasses/ Contacts	Y	N
Recent Weight Change	Y	N	Sinus Problems	Y	N	Blurred/ Double Vision	Y	N
Night Sweats, Fevers	Y	N	Nose Bleeds	Y	N	Eye Disease or Injury	Y	N
Fatigue	Y	N	Sore Throat/ Voice Change	Y	N	Glaucoma	Y	N
<b>CARDIOVASCULAR</b>	YES	NO	<b>RESPIRATORY</b>	YES	NO	<b>GASTROINTESTINAL</b>	YES	NO
Chest Pain	Y	N	Shortness of Breath	Y	N	Nausea/Vomiting	Y	N
Palpitations	Y	N	Cough	Y	N	Abdominal Pain	Y	N
Heart Trouble	Y	N	Wheezing/ Asthma	Y	N	Rectal Bleeding	Y	N
Swelling Hands/ Feet	Y	N	Coughing Up Blood	Y	N	Bowel Problems	Y	N
<b>MUSCULOSKELETAL</b>	YES	NO	<b>NEUROLOGICAL</b>	YES	NO	<b>SKIN/BREAST</b>	YES	NO
Muscle Pains/Cramps	Y	N	Frequent Headaches	Y	N	Changes in Hair or Nails	Y	N
Stiffness/Swelling Joints	Y	N	Paralysis or Tremors	Y	N	Rashes or Itching	Y	N
Joint Pain	Y	N	Convulsion/Seizures	Y	N	Breast Lump	Y	N
Trouble Walking	Y	N	Numbness/ Tingling	Y	N	Breast Pain or Discharge	Y	N
<b>ENDOCRINE</b>	YES	NO	<b>HEMATOLOGIC/LYMPHATIC</b>	YES	NO	<b>ALLERGIC/IMMUNOLOGIC</b>	YES	NO
Excessive thirst/urination	Y	N	Bruise Easily	Y	N	Food Allergies	Y	N
Thyroid Disease	Y	N	Slow to Heal	Y	N	Aspirin Allergies	Y	N
Hormone Problem	Y	N	Enlarged Glands	Y	N	Antibiotic Allergies	Y	N
<b>GENITOURINARY-MALE</b>	YES	NO	<b>GENITOURINARY-FEMALE</b>	YES	NO	<b>PSYCHIATRIC</b>	YES	NO
Blood in Urine	Y	N	Blood in Urine	Y	N	Insomnia	Y	N
Kidney Stones	Y	N	Kidney Stones	Y	N	Confusion/Memory Loss	Y	N
Sexual Problems	Y	N	Sexual Problems	Y	N	Depression	Y	N
Testicle Pain	Y	N						

**SOCIAL HISTORY (Please circle appropriate response)**

**Marital Status:**      Single                      Married/Divorced                      Widowed

**Tobacco Use:**        Never                      Quit/When? \_\_\_\_\_                      Current Smoker                      \_\_\_\_\_ packs per day

**Alcohol Use:**        Never                      Rarely                      Moderate                      Daily                      How Much? \_\_\_\_\_

**Drug Use:**            Never                      Type & Frequency \_\_\_\_\_

**PATIENT STATEMENT: To the best of my knowledge, the above information is accurate and complete.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_