Florida Heart & Vascular
Multi-Specialty Group

Experience Our Integrity and Compassionate Care

Cardiology

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
Michael Ruisi, MD

Vascular Surgery

David Sustarsic, MD, FACS
Jonathan A. Higgins, MD, RPVI

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
Justin P. Morgan, DO
Robert A. Aisenstat, MD
Michael McGinnity, PA

Debbie Pate, ARNP, ANP-C
Tara Brannen, ARNP
Kari Baron, FNP

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
John Hayes, 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 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

Florida Heart & Vascular
Multi-Specialty Group
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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
_____Discharge Summary
_____Lab Results
_____EKG(s)
_____Echocardiogram Report(s)
_____Chest X-Ray Report(s)
_____Most Recent Office Notes
_____Stress Test Report(s)
_____ Cardiac Catheterization Report(s)
_____Cardiac Catheterization Images
_____Peripheral Ultrasound Report(s)
_____Abdominal Ultrasound Report(s)
_____Carotid Ultrasound Report(s)
_____Peripheral Angiogram Report(s)
_____Peripheral Angiogram Images
_____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

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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:

Name	**Relationship to Patient**	**Phone Number**
Name	**Relationship to Patient**	**Phone Number**
Name	**Relationship to Patient**	**Phone Number**
Name	**Relationship to Patient**	**Phone Number**

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

Patient Name (PRINT)	**Date of Birth**	**SSN**
	/ /	- -

Patient Signature	**Date** / /
Witness Signature	**Date** / /

511 Medical Plaza Drive, Suite 101
Leesburg, FL 34748
(352)728-6808 Fax: (352)728-3637

1560 Santa Barbara Boulevard
The Villages, FL 32159
(352)750-5000 Fax: (352)750-5004

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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

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).

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

Pharmacy and Phone Number _____

All Physicians that you are currently under the care of

Physician, Specialty	Office phone number
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

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

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 _____
_____
_____
_____
_____
_____
_____
_____
_____

Family Information	Age	Health	Age at Death	Cause of Death
Father				
Mother				
Siblings				
Children				
Spouse				

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

Heart disease	NO	YES	Thyroid disease	NO	YES
Stroke	NO	YES	Diabetes	NO	YES
High blood pressure	NO	YES	High Cholesterol/ Triglyceride	NO	YES