809 CR 466 Suite 101-C
Lady Lake, FL 32159

Cardiac Specialty Institute

803 E Dixie Ave
Leesburg, FL 34748

Office: 352-530-2256 Fax: 352-315-0069

Dr. Sanjeev Bhatta, MD Ronnie Sabbah, MD Steven Sywenki, ARNP-c

PATIENT INFORMATION SHEET

Last Name: _____ First Name: _____ MI:____
Street Address: _____
City: _____ ST: _____ ZIP: _____
Street Address: _____
City: _____ ST: _____ ZIP: _____
Home Phone: (____)_____-_____ Cell : (____)_____-_____
Date of Birth: ____/____/_____ Male or Female SS# _____-_____-_____
Martial Status: Married, Divorced, Single, Widowed
Reason for appointment: _____

Emergency Contact:
Name: _____ Relationship: _____ Phone: (____)_____-_____
Name: _____ Relationship: _____ Phone: (____)_____-_____

Referring Physician:
Physician Name: _____ Phone: (____)_____-_____
Reason for Referral: _____

Primary Physician:
Physician Name: _____ Phone: (____)_____-_____

Primary Insurance:
Insurance Company: _____ Phone: (____)_____-_____
Subscriber Number: _____ Group Number: _____

Policy Holder Name (If not self)
Last Name: _____ First Name: _____ MI:____
Date of Birth: ____/____/_____ SS# ____-____-_____ Relationship: _____

Secondary Insurance:
Insurance Company: _____ Phone: (____)_____-_____
Subscriber Number: _____ Group Number: _____

Policy Holder Name (If not self)
Last Name: _____ First Name: _____ MI:____
Date of Birth: ____/____/_____ SS# ____-____-_____ Relationship: _____

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Patient Name: _____ Date of Birth: ____/____/_____

Medications:

Name of Medication:	Dosage:	Reason for medication:

Allergies

Medication, Food, Other:	Reaction:

Past/Recent Hospitalizations and/or Surgeries

Date:	Location:	Hospitalization reason or type of surgery:
/ /		
/ /		
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Review of Symptoms:

Patient Name: _____ Date of Birth: ____/____/_____

General	YES	Cardiovascular	YES	Endocrine	YES
Fever of chills		Chest Pain with activity		Night sweats	
Recent weight change		Chest Pain at rest		Excessive thirst	
Fatigue		Heart skips beats		**Psychiatric**	**YES**
Heat or cold intolerance		Heart beats too fast		Depression	
Head or Neck	**YES**	Passing out spells		Anxiety	
Swelling in neck		High Blood Pressure		Nervous breakdown	
Prolonged hoarseness		Low Blood Pressure		Alcohol problems	
Sore Throat		Heart Murmur		Drug problems	
Pain or stiffness in neck		Bad Heart Valve			
Skin	**YES**	Rheumatic Fever			
Rash, dryness, itching		Feet or ankle swelling			
Change in nails/skin color		Short of breath at rest			
Bleeding, bruising		Short of breath with activity			
Eyes	**YES**	Short of breath laying down			
Double, failing vision		Feet or ankle swelling			
Pain or light sensitivity		**Lungs**	**YES**		
Gastrointestinal	**YES**	Cough			
Abdominal Pain		Cough with septum or blood			
Blood in stool		Wheezing			
Change in bowel		COPD			
Constipation		Dyspnea			
Diarrhea		Hemoptysis			
Heartburn		Pain while breathing			
Nausea		Chest congestion			
Vomiting					

Past and Family Medical History: Please check if you or your family have ever had any of the following:

If family, please circle F-father, M-mother, S-sibling, G-grandparent

	YOU	FAMILY		YOU	FAMILY
Hypertension		F M S G	Blood Clots		F M S G
Heart Disease		F M S G	Tuberculosis		F M S G
Stomach Ulcers		F M S G	Blood Disorder		F M S G
Seizure/Epilepsy		F M S G	Lupus		F M S G
Diabetes		F M S G	Stroke		F M S G
Cancer		F M S G	Thyroid Disease		F M S G
Renal Disease		F M S G	Liver Disease/Hepatitis		F M S G
PVD		F M S G	Aortic Aneurysm		F M S G
			CAD		F M S G

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Social History:

What is/was your occupation?: _____ Disabled: Yes or No

Drug Use:

I use one or more of the following:

(Please circle all that apply or None of the Above)

Marijuana Heroin
Cocaine Illicit Prescriptions
Crack None of the Above

Smoking History:

Are you a current smoker? Yes or No Year started: _____
If not current, are you a former smoker? Yes or No Year Quit: _____
If current:
Number of years: _____
Packs per day: _____

Drinking History?

Do you drink? Yes or No Year started: _____ Year Quit: _____
Beer: _____ per _____ **Wine:**____ per_____ **Mixed Drinks:** _____ per_____

Special Diet:

Are you on a special diet? Yes or No (If yes, please circle which one)
Low Salt
Diabetic
Calorie Limited
High Fiber
Low Cholesterol

Exercise:

Do you exercise? Yes or No
Type of exercise? _____ Daily Weekly
Type of exercise? _____ Daily Weekly

** Please fax most RECENT records to 352-315-0069. If over 25 pages please mail out**

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Medical Release Form

Patient Name: _____ Date of Birth: ____/____/_____

SS# ____-_____-_____

I hereby authorize Cardiac Specialty Institute to obtain my medical records from:

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone: (____)_____-_____
Fax : (____)_____-_____

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone: (____)_____-_____
Fax : (____)_____-_____

Information to be disclosed:

____Complete Chart
____Records from _____ to _____
____ Other: _____

Purpose of Disclosure:

_____Continuing Care
_____Payment of Claim
_____School
_____Legal
_____Personal Use
_____Other: _____

I specifically authorize the release of information relating to: (For consent initial by each one)

_____Substance Abuse
_____Behavioral Health
_____HIV Related Information
_____Communicable Disease

Acknowledgement of Understanding:

* I understand the expiration date of authorization is ONE year
* I understand that I may revoke this authorization at any time in writing. It will be effective on the date notified except to the extent action that has already been taken.
* I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by federal privacy regulation.
* I understand by authorizing the use of disclosure of information, there will no conditions placed on my health care or payment for my healthcare.
* I understand that I have a right to receive a copy of this form after I have signed it.
* I understand that in compliance with Florida Law, I may be required to pay a fee for the retrieval and photocopying of records and/ or supervising inspection of those medical records.

Patient /Guardian Signature: _____ Date: _____/_____/_____

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HIPPA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your condition and your diagnosis (including treatment, payment, and health care operations):

Name: _____ Phone: (____)_____-_____
Name: _____ Phone: (____)_____-_____
Name: _____ Phone: (____)_____-_____

2. Please list the family members or other person(s), if any, whom we may inform about your condition **ONLY IN AN EMERGENCY.**

Name: _____ Phone: (____)_____-_____
Name: _____ Phone: (____)_____-_____
Name: _____ Phone: (____)_____-_____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent **if other than your home. (Confidential Communications)**

Street Address: _____ City: _____ ST: _____ ZIP: _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL"**.

____YES _____NO

I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

Patient Name: _____

Patient /Guardian Signature: _____ Date: _____/_____/_____

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Notice of Privacy Practice Acknowledgement Form:

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk.

You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment or healthcare operations as described in our notice. You have the right to revoke this consent in writing, expect when we have already made releases in reliance on your prior consent.

Patient Name: _____ Date of Birth: ____/____/_____

Patient /Guardian Signature: _____ Date: _____/_____/_____

Witness Name: _____

Witness Signature: _____ Date: _____/_____/_____

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Authorization To Release Information

I, hereby authorize Cardiac Specialty Institute to disclose the specific information described below, only for the purpose and to the parties below.

Name: _____ Relationship: _____ Phone: (____)_____-_____
Name: _____ Relationship: _____ Phone: (____)_____-_____
Name: _____ Relationship: _____ Phone: (____)_____-_____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

NOTICE OF PRIVACY PRATICES ACKNOWLEDGEMENT: I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights regarding my protected health information. I understand that this information will be shared to plan, direct and follow up patient care among multiple providers who may be involved in my treatment, directly and indirectly and to obtain payment from third policy payers. I acknowledge that I have received the notice of practices which contains a more complete description of the uses and disclosure of my health information. I understand that Cardiac Specialty Institute has the right to change its notice and privacy practices from time to time and I may contact Cardiac Specialty Institute at any time, to address and obtain a new copy of the privacy practices. I also understand that I may request in writing that you restrict my private information that is used or disclosed to carry out treatment, payment of healthcare operations. I understand that Cardiac Specialty Institute is not required to agree to my requested restrictions and I understand and agree that I am bound by such restrictions.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient /Guardian Signature: _____ Date: _____/_____/_____

Patient /Guardian Printed: _____ Date: _____/_____/_____

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Advance Directives

Advance Directives are a written statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Other put their wishes into writing while they are healthy, often as part of their estate planning.

Do you have any of the following Advance Directives? If so, please provide our office with a copy.

_____ **Living Will:** Which is a written statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because if takes effect while you are still living.

_____ **Health Care Surrogate Designation:** It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will.

_____ **Do Not Resuscitate Order:** Which is a form or patient identification device developed by the Department of Health to identify people who do not wish to be resuscitated in the event of respiratory or cardiac arrest.

Patient Name: _____ Date of Birth: ____/____/_____