



Northwest Houston Heart Center

A. Adnan Aslam, MD FACC, FSCAI

308 Holderrieth, Tomball, Texas 77375 - Tel: 281.351.4911 - Fax: 281.351.4915

New Patient Form

DATE: _____

PATIENTS NAME: _____

AGE: _____ DATE OF BIRTH: _____ SEX: Male Female

REFERRING DOCTOR: _____

ADDRESS: _____

CHIEF COMPLAINTS:

HISTORY OF PRESENT ILLNESS:

PHYSICAL EXAM: (+) POSITIVE OR ABNORMAL

Patient initials ...



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Check all that apply (√)

Past Medical History	Yes	No
HYPERTENSION	_____	_____
DIABETES	_____	_____
ANGIOPLASTY / STENT	_____	_____
CORONARY ARTERY BYPASS	_____	_____
HEART ATTACK	_____	_____
CORONARY ARTERY DISEASE	_____	_____
PULMONARY DISEASE	_____	_____
ASTHMA	_____	_____
STROKE	_____	_____
PERIPHERAL VASCULAR DISEASE	_____	_____
DEEP VEIN THOMBOSIS	_____	_____
PULMINARY EMBOLISM	_____	_____

Past Surgical History: INCLUDE DATE AND TYPE OF SURGERY

Family History:

NONE

- _____ HYPERTENSION
- _____ DIABETES
- _____ HEART ATTACK
- _____ SUDDEN DEATH
- _____ CHRONIC OBSTRUCTIVE PULMINARY DISEASE
- _____ ASTHMA
- _____ CANCER

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Social History:

OCCUPATION: _____

DRINK ALCOHOL: YES HOW MUCH _____ NO

Your Risk Factors:

	Yes		No
FAMILY HISTORY OF CAD	_____		_____
HIGH COLESTEROL	_____		_____
SMOKING / PACK PER DAY	_____	YRS	_____
SEDENTARY LIFESTYLE	_____		_____
TYPE "A" PESONALITY	_____		_____
HYPERTENSION	_____		_____
DIABETES	_____		_____

Are you Allergic to any Medications?:

Iodine Dye Allergy: YES NO DON'T KNOW



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Review of Systems:

- General:** Weight gain Weight loss Night sweats Fever
 Insomnia Snoring Restless Sleep

- Eyes:** Change in visual ACUITY Double vision Blurring
 Cataracts Pain

- Ent:** Dizziness Hearing Loss Nasal Discharge Sore throat
 Enlarged Lymphnodes

Cardiovascular

- Chest pain Syncope (passing out) Palpitations
 Heart murmur

Respiratory:

- Shortness of breath Asthma Cough
 Sputum Phlegm

- GI:** Change in bowel habits Ulcer Liver disease
 Colitis Irritable bowl Polyps

- GU:** Kidney disease Incontinence Bladder problems Impotence
 Prostrate problems

Muskoskeletal:

- Bone disease Fractures Falls Trauma
 Scoliosis

Extremities:

- Pain in Legs when walking (Claudication) Ankle Swelling Temp changes

Psychiatric:

- Depression Bipolar disease Hospitalization

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Expanded Vital Sign Assessment

Please answer the following questions and provide to your practitioner upon check-in.

Fluid Management	Yes	No
Have you every been diagnosed with heart failure?		
Do you have ankle swelling?		
Do you have increased shortness of breath, for instance walking a short distance such as from the parking lot to the physician's office?		
Have you been hospitalized or had a procedure for your heart since your last visit?		
Have you had your heart failure medication or diuretics changed recently?		
Do you wake up at night with shortness of breath?		
Have you had to sleep on more than one pillow to breathe comfortably at night?		

Determination of the Cause of Shortness of Breath	Yes	No
Do you have trouble breathing at times?		
Do you have a combination of cardiac and pulmonary problems?		

Resistant Hypertension or High Blood Pressure	Yes	No
Have you been told that you have high blood pressure?		
Are you taking a diuretic (water pill) for your high blood pressure?		
Are you taking at least three medications for your high blood pressure?		

Name: _____ Signature: _____

Date: _____

Note to medical staff: If your patient answers YES to one or more of the above EVS questions, then perform the BioZ (expanded vital sign) before the patient is seen by MD and place the status report and questionnaire on chart.

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DATE: _____ PCP: _____

PATIENT INFORMATION

NAME: _____

LAST

FIRST

MIDDLE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL: _____

SEX: MALE FEMALE BIRTHDATE: _____ CHILD SINGLE MARRIED OTHER

SS# _____ EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY INSURANCE

DO YOU HAVE MEDICARE YES NO IF YES, ENTER NUMBER: _____

INS CO NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INS CO. PHONE: _____ GROUP# _____ ID# _____

POLICY HOLDER NAME: _____ RELATIONSHIP SELF SPOUSE CHILD OTHER

EMPLOYER: _____ SS# _____ BIRTHDATE: _____

ADDITIONAL INSURANCE

INS CO NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INS CO. PHONE: _____ GROUP# _____ ID# _____

POLICY HOLDER NAME: _____ RELATIONSHIP SELF SPOUSE CHILD OTHER

EMPLOYER: _____ SS# _____ BIRTHDATE: _____

MEDICAL INFORMATION

HAVE YOU SEEN THE PHYSICIAN BEFORE YES NO / IF YES WHERE? _____

REASON FOR VISIT: _____

MEDICAL ALLERGIES: _____

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Patient Financial Policy

To refuse confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Fees and Payments

We share your concerns about rising health care costs. Our fees represent usual and customary charges based on community standards. Patients are expected to pay for professional services at the time of the visit. Our policy is to collect this co-payment when you arrive for your appointment. All forms of payment are accepted including MasterCard, Visa, American Express, Discover, and personal checks. If you have any questions about our fees, please feel free to discuss them with us.

Insurance

We have a contract with many health plans to accept an assignment of benefits. We will bill these plans and will require the patient to pay authorized co-payments, coinsurance, and deductibles at the time the services are rendered. The responsibility for payment of medical care costs is the direct responsibility of the patient. All patients are responsible for fees and not payable, which includes co-payments, deductibles, and coinsurances. The remaining balance is due within one month of notice from the insurer. The patient is responsible for obtaining authorization from his or her primary care physician. The patient is responsible for understanding the authorization process and the payment process of his or her insurance company.

Physician Authorization and Assignment of Benefits

I hereby authorize Northwest Houston Heart Center to release any information and diagnosis requested by my insurance company. I understand that this information will include, where applicable, specific laboratory test results including HIV infection of the diagnosis of acquired immune deficiency syndrome. I further authorize payment directly to the undersigned physician for the surgical and or medical payables under my plan for services provided to me.

Privacy Policy Provided upon Request

Printed Name of Patient: _____

Signature of Patient: _____ Date: _____

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