NORTHWEST HOUSTON HEART CENTER

A. ADNAN ASLAM
MD, FACC, FSCAI

SAMUEL J. FERRIS
MD, FACC

TAYYAB MOHYUDDIN
MD, FACC

NEW PATIENT FORMS

DATE: _____

PATIENT'S NAME: _____

AGE: _____ DATE OF BIRTH: _____

REFERRING DOCTOR: _____

What is the main reason for you to see Cardiologist on this visit?

_____

_____

_____

If you are having any abnormal symptoms, please explain briefly here:

_____

_____

_____

Current Medications with Dosages:

Please list them here or give them to staff when you get in to exam room:

1.		4.	
2.		5.	
3.		6.	

Note: *If you have already filled out social and family history, past medical history, and review of symptoms sections on our web portal, you don't need to complete the pages 2 to 4 of this package.*

Patient's initial: _____

308 Holderrieth Blvd.
Tomball, TX 77375

18220 Tomball Parkway, Suite 205
Houston, TX 77070
(inside Methodist Willowbrook Hospital)

18230 FM 1488, Suite 201
Magnolia, TX 77354

Phone: 281-351-4911 Fax: 281-351-4915 • www.houstonheartcenter.com

Check all that apply (√)

S.No.	Past Medical History	Yes	No	Don't Know
1.	Coronary Artery Disease			
2.	Heart Attack			
3.	Cardiac Arrest			
4.	Angioplasty or Stent of Heart Arteries			
5.	Coronary Artery Bypass			
6.	Peripheral Vascular Disease (PAD or PVD)			
7.	Angioplasty or Stent of Leg Arteries			
8.	Carotids Stenosis (Blockage)			
9.	Carotids Artery Surgery or Stent			
10.	Abdominal Aortic Aneurysm			
11.	Stroke			
12.	Atrial Fibrillation or Atrial Flutter			
13.	Diabetes			
14.	High Cholesterol			
15.	High Blood Pressure			
16.	Pacemaker Placement			
17.	Defibrillator Placement			
18.	Congestive Heart Failure			
19.	Asthma			
20.	COPD			
21.	Blood Clots in Lungs (Pulmonary Embolism)			
22.	Blood Clots of Leg Veins (DVT)			
23.	Thyroid Abnormalities			
24.	Any other significant Medical or Surgical History			

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Check all that apply (√)

Family History	Yes	Relationship	No	Don't Know
Heart Attack				
Heart Stent or Bypass Surgery				
Sudden Cardiac Death				
Stroke				
Carotid Artery Surgery				
Congestive Heart Failure				
Any Other Significant Heart History				
Pacemaker Placement				
Cancer				

Social History:

Are you married? ☐ YES ☐ NO
Do you currently smoke? ☐ YES *How many cigarettes/day*_____ ☐ NO
Have you ever been a smoker? ☐ YES *How many/day*____*How long*_____ ☐ NO
Do you currently drink alcohol? ☐ YES *How much*_____*How often*_____ ☐ NO
Do you use recreational drugs? ☐ YES ☐ NO
Occupation: _____

Recent Hospitalization/Major Diagnostic Procedures: ☐ YES ☐ NO
If yes, please specify When, Where, and Reason for Hospitalization:
_____
_____

Allergies to any Medications: ☐ YES ☐ NO
If yes, please list the name of medications and type of reaction you had:
_____
_____

Allergy to Iodine Dye: ☐ YES ☐ NO ☐ DON'T KNOW
If yes please describe the kind of reaction you had to dye exposure:
_____
_____
_____
_____

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Circle all that apply

S No.	Review of Systems	Descriptions
1.	**Constitutional**	weight gain, fever, restless sleep, weight loss, snoring, fatigue
2.	**Ophthalmology**	change in visual acuity, double vision, cataracts, blurring of vision, pain in eyes, loss of vision
3.	**ENT**	dizziness, nasal discharge, enlarged lymph nodes, hearing loss, sore throat
4.	**Cardiology**	chest pain, palpitations, heart murmur, syncope or passing out
5.	**Respiratory**	shortness of breath, asthma, cough, phlegm
6.	**Gastroenterology**	irritable bowl, polyps, change in bowel habits, colitis, ulcer, liver disease
7.	**GU**	kidney disease, bladder problems, urinary incontinence, prostrate problems
8.	**Musculoskeletal**	joint swelling, joint pain, leg cramps, joint stiffness, sciatica, osteoporosis, fracture, carpal tunnel
9.	**Psychiatrics**	high stress level, depression, sleep disturbances, eating disorder, anxiety
10.	**Endocrinology**	weight loss, sleep disturbance, cold intolerance, heat intolerance, diabetes, thyroid abnormalities
11.	**Neurology**	headache, tingling numbness, seizures, memory loss, dizziness, gait abnormality
12.	**Dermatology**	rash, hives, skin cancer, frequent bruising

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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 ever been diagnosed with congestive 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: _____

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Risk Factors for PAD and CVI Testing

Do you have any of the given risk factors or medical conditions? Answers to these questions will help us better assess your vascular health status.

Name: _____ Date: _____

Circle "Yes" or "No"		
1	Coronary Artery Disease	Yes
2	Carotid Stenosis or H/o stroke or TIA	Yes
3	Diabetes	Yes
4	Hypertension	Yes
5	High Cholesterol	Yes
6	COPD	Yes
7	Renal Failure	Yes
8	Tobacco Use	Yes

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Do I Need a Test for CVI?

Chronic Venous Insufficiency (CVI) is a serious circulatory problem in which the leg veins cannot pump enough blood back to your heart. It affects over 2.5 million Americans, most over the age of 40. Symptoms of CVI include varicose veins, skin problems, leg and ankle swelling, tight calves, and legs that feel heavy, tired, restless, or achy. Factors that can increase the risk of CVI include pregnancy, obesity, smoking, standing or sitting for long periods of time and not getting enough exercise. Answers to these questions will determine if you are at risk for CVI and if a vascular exam will help us better assess your vascular health status.

	Circle "Yes" or "No"	
1	Are your legs swollen, painful, red or warm to the touch?	Yes
2	Have you had a blood clot in a vein that caused inflammation, pain or irritation?	Yes
3	Do you have varicose veins (veins that are enlarged or swollen and raised above the surface of the skin) in the legs?	Yes
4	Have you had a Deep Vein Thrombosis (DVT) in the past and are experiencing pain, swelling, changes in skin color, cellulites, or non-healing ulcers?	Yes
5	Do you r legs feel heavy, tired, restless or achy?	Yes
6	If you push on your swollen foot, ankle or leg for 10 seconds and release, does your fingerprint leave a dimple?	Yes
7	If your feet, ankles and legs are swollen, does the skin look stretched or shiny?	Yes
8	Do you have an ulcer on the inside of your ankle?	Yes

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Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

	Circle "Yes" or "No"	
1	Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes
2	Do you experience any pain at rest in your lower leg(s) or feet?	Yes
3	Do you experience foot or toe pain that often disturbs your sleep?	Yes
4	Are your toes or feet pale, discolored, or bluish?	Yes
5	Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes
6	Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes
7	Have you suffered a severe injury to the leg(s) or feet?	Yes
8	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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DATE: _____ PCP: _____

PATIENT INFORMATION:

NAME: _____ DOB: _____

Last First Middle

SS# _____ STATUS: ☐ Single ☐ Married ☐ Other _____

GENDER: ☐ Male ☐ Female LANGUAGE: ☐ English ☐ Spanish ☐ Other___

RACE: ☐ White ☐ Hispanic ☐ Black/African American ☐ Asian ☐ Other_____

ETHNICITY: ☐ Hispanic ☐ Not Hispanic ☐ Refused To Report

ADDRESS: _____

CITY: _____ STATE: _____ZIP: _____

PHONE HOME: _____WORK: _____CELL:_____

EMAIL: _____

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#_____DOB: _____

ADDITIONAL SECONDARY INSURANCE:

INS CO NAME: _____ ADDRESS: _____

CITY: _____STATE:_____ZIP: _____

INS CO. PHONE: _____GROUP#_____ID#_____ -

POLICY HOLDER NAME: _____

RELATIONSHIP: ☐ Self ☐ Spouse ☐ Child ☐ Other

EMPLOYER: _____ SS#_____DOB: _____

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PATIENT FINANCIAL POLICY AND CONSENT FORM

Patient Financial Policy:
To avoid 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 provide the best possible care and service to our patients.

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 Cash, Personal checks, Debit cards and Credit cards including MasterCard, Visa, American Express, Discover. If you have any questions about our fees, please feel free to discuss 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 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 medical information and diagnosis requested by my insurance company and my treating physicians. I understand that this information will include, where applicable, all the work up and testing, diagnosis. Treatment plans also including all the blood work and specific laboratory test results including HIV testing for the diagnosis of acquired immune deficiency syndrome. I further authorize payment directly to the assigned physician for the surgical and or medical payables under my plan for services provided to me.

This form continues on next page

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Authorization to Release Medical Records:

I am writing to authorize Northwest Houston Heart Center to obtain my medical records on my behalf. Please send my medical records by fax at 281-351-4915 or by mail at following address:

NORTHWEST HOUSTON HEART CENTER, P.A.
308 HOLDERRIETH BOULEVARD
TOMBALL, TEXAS, 77375-4536

Advance Beneficiary Notice of Noncoverage (ABN):

You are receiving this notice because your insurance company may not pay for all the services that you receive during your visits to our office. You need to read this notice so that you can make an informed decision about your care. If your insurance carrier denies payment, then you are completely responsible for payment in full to the services rendered to you at this facility. You understand that you can appeal this decision for nonpayment to your insurance carrier. By this notice, you agree to take financial responsibility for the cost of the supplies and services rendered to you at your visit to our facility, if your insurance company denies coverage for the same. If you do not want any service not covered by your insurance company, please inform us in writing at the time of check in.

Patient Signature _____ Date: _____

Witness Signature _____ *Date:* _____

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