Heart and Vascular Wellness Center

Patient Information

Please print. All Information is Confidential

Patient Name: _____ **Male** **Female** **Date of Birth:** _____

SSN: _____ **Phone #:** _____ **Alternative phone #:** _____

Address: _____
Address City State Zip

Email Address: _____

Circle appropriate status: **Minor** **Single** **Married** **Divorced** **Widowed** **Separated**

Spouse/Partner Name: _____ **Phone#:** _____

May we contact your spouse/partner if we cannot contact you **Yes** **No**

Person to Contact in case of an emergency (not residing with you)

_____
Name Relationship Phone Number

Employer: _____ **Work #:** _____

***Preferred Pharmacy*:** _____ **Phone #:** _____

***Primary Physician*:** _____ **Phone#** _____

***Referring Physician*:** _____ **Phone#** _____

INSURANCE INFORMATION

Insurance Holder: _____ Relationship to patient: _____

Date of Birth: _____ SSN: _____

Insurance Company: _____ ID#: _____ Group# _____

Insurance Company Address: _____
Address City State Zip

Do you have any additional insurance? Yes No

Insurance Holder: _____ **Relationship to patient:** _____

Date of Birth: _____ **SSN:** _____

Insurance Company: _____ **ID#:** _____ **Group#:** _____

Insurance Company Address: _____
Address City State Zip

CONSENT FOR TREATMENT

I hereby authorize and direct the physicians of Heart and Vascular Wellness Center to examine and treat me as is needed in their judgement. I acknowledge that the examination may include physical contact by the physician and/or his assistants.

_____ _____
Patient signature ***Date***

40700 California Oaks Rd # 208, Murrieta, CA 92562 Phone: 951-696-0004 Fax: 951-696-0007

NOTICE OF PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing ***Heart and Vascular Wellness Center*** as your healthcare provider.

Please read the following information regarding insurance coverage and your financial responsibility. Although we will make every attempt to verify your insurance coverage and benefits, it is also your responsibility to understand your coverage. Despite these efforts, if for any reason your insurance company does not pay, you may be financially responsible for your healthcare services.

Insurance Coverage
It is your responsibility to understand your insurance coverage and benefits. We will assist in verification of your coverage and benefits and exclusions, but if for any reason your insurance does not make payment, you may be financially responsible for balances.

Insurance Changes
If you have had any changes to your insurance carrier, it is your responsibility to notify us immediately and prior to your services being provided. If your coverage is not in effect for the date of your service, you will be responsible for the balance.

Co-payments, Co-Insurance and Deductibles
Co-Insurance and Co-Payments are the patient's responsibility and are due at the time of service. Deductibles are the responsibility of the patient and are determined by your insurance coverage. We will attempt to determine the amount that you will be responsible for prior to your service, but since this will vary depending on other healthcare services that you have received recently this amount may differ and amounts may become due after we receive payment from your insurance company. We will send you a statement with the balance due. This information will also be available on the Explanation of Benefits you will receive from your insurance company.
Returned checks will be charged a service fee of $35.

Referrals
Your insurance company may require obtaining a prior authorization for services. We will assist in obtaining the referrals needed. If you have changed your primary care physician it may be necessary to obtain a new referral, so please let us know each time you change your primary care provider.

Non-Covered Services
Patients are responsible for all "non-covered" services if they are denied by your insurance company. Please be aware of exclusions to your coverage.

Insurance Forms/Requests
You are responsible for timely responding to requests from your insurance company. Failure to do so will result in a denial of payment to us and you are responsible for the payment.

Insurance Payments
If an insurance payment is sent to you in error please forward the payment along with a copy of the Explanation of Benefits to our office within 10 days of receipt.

We appreciate the confidence you put in us to provide you with excellent healthcare.

I have read and understand this financial responsibility form.

Patient Name _____

Signature _____ **Date** _____

Heart and Vascular
Wellness Center

Heart and Vascular Wellness Center
40700 California Oaks Rd. Suite 208
Murrieta, CA 92562
P: (951) 696-0004 F: (951) 696-0007

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

I _____ acknowledge that I have received a copy of Heart and Vascular Wellness Center's ***Notice of Privacy Practices.*** This notice describes how Heart and Vascular Wellness Center may use and disclose my protected health information, certain restrictions on the use and disclose of my healthcare information, and rights I may have regarding my protected health information.

I fully understand and accept the terms of this consent

_____ _____
Signature of Patient or Representative *Date*

_____
Relationship to Patient

I choose to allow the following individuals to have access to my medical records and any information regarding my condition and treatment.

_____ _____
Name *Name*

_____ _____
Relationship to patient *Relationship to patient*

_____ _____
Contact # *Contact #*

_____ _____
Signature of Patient ***Date***

Heart and Vascular Wellness Center

Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

Patient Social Security Number: _____ Contact Number: _____

I hereby Authorize: Heart and Vascular Wellness Center

40700 California Oaks Rd Suite 208

Murrieta, CA 92562

P: (951) 696-0004 F: (951) 696- 0007

☐ *To obtain my information from* or ☐ *Release my information to*

Facility Name: _____

Fax: _____

STATUS: ☐ ***STAT*** ☐ 2nd ATTEMPT ☐ Patient Appointment: _____

This authorization is for full disclosure of all medical records. Including:

Dates of Treatment: _____

☐ ER Records	☐ OP Reports	☐ Office/Clinic Visit
☐ Discharge Summary	☐ Radiology Reports	☐ Lab Reports
☐ Pathology Reports	☐ H&P, Consults, Progress Notes	☐ Cardiology/Cardiovascular records

☐ Other: _____

The above information is released for the following purpose and that purpose only:

☐ Continuation of Care	☐ Legal Purposes	☐ Insurance Purposes
☐ Personal Reasons	☐ Employer Requirement	☐ Other: _____

_____

Signature of Patient

_____

Print Patient Name

_____

Date

PATIENT INFORMATION:

Name:_____ DOB:_____

Cardiovascular History/ Procedures

Please indicate if you have had any of the following events or procedures

Procedure	***Dates***	***Hospital/Facility***
Heart Attack ☐ Yes ☐ No	_____	_____
Heart Catheterization/ Coronary Angiogram/ Stents ☐ Yes ☐ No	_____	_____
Echocardiogram ☐ Yes ☐ No	_____	_____
Stress Test ☐ Yes ☐ No	_____	_____
Electrical Cardioversion ☐ Yes ☐ No	_____	_____
Electrophysiology Study/ Ablation of abnormal heart Rhythm ☐ Yes ☐ No	_____	_____
Angiogram/Angioplasty of the extremities ☐ Yes ☐ No	_____	_____
Venous Ablation/ Vein Stripping ☐ Yes ☐ No	_____	_____
Cardiac Surgery / CABG/ Bypass ☐ Yes ☐ No	_____	_____
Valve Surgery / Valve Replacement ☐ Yes ☐ No	_____	_____
Pacemaker / Defibrillator ☐ Yes ☐ No	_____	_____
Holter/ Heart Monitor ☐ Yes ☐ No	_____	_____
Recorder/ Implantation Heart Monitor ☐ Yes ☐ No	_____	_____

Name: _____

Symptom Checklist

1) Have you experienced tiredness, heaviness, or cramping in the leg muscles? ☐ Yes ☐ No
2) Do your toes or feet look pale, discolored or bluish? ☐ Yes ☐ No
3) Pain in legs and/or feet that disturbs sleep? ☐ Yes ☐ No
4) Sores or wounds on toes, feet, or legs that heal slowly or not at all? ☐ Yes ☐ No
5) One leg or foot feels colder than the other? ☐ Yes ☐ No
6) Poor nail growth and decreased hair growth over time on toes and legs? ☐ Yes ☐ No

Present Medical Condition

Check all that apply

General

☐ Fatigue
☐ Poor Appetite
☐ Weight loss
☐ Fever/ Night Sweats
☐ Anemia

Respiratory

☐ Frequent Coughing
☐ Coughing up blood
☐ Wheezing
☐ Stop breathing while Sleeping

Cardiovascular

☐ Shortness of breath
☐ Chest/Arm pain/Pressure
☐ Racing/Irregular heartbeats
☐ Fainting or near fainting
☐ Swelling of the ankles
☐ Discomfort in calf of leg triggered by walking
☐ Varicose veins
☐ Leg swelling

Skin

☐ Skin Rash
☐ Itching
☐ New growth/ change of mole

Breast

☐ Lumps
☐ Discharge

Urinary System

☐ Blood in urine
☐ Pain with urination
☐ Difficulty urinating
☐ Frequent urination at night

Nervous System/ Psychological

☐ Severe Headaches/Migraines
☐ Numbness on one side
☐ Memory loss
☐ Numbness or burning of feet
☐ Anxious/ Depression

Eyes/ Ears/ Nose / Throat

☐ Trouble seeing (without glasses)
☐ Hearing loss
☐ Nosebleeds
☐ Teeth / Gum infection

Digestive System

☐ Abdominal Pain
☐ Heart burn
☐ Difficult Swallowing
☐ Bleeding from stomach/ bowel
☐ Nausea / Vomiting
☐ Diarrhea
☐ Constipation

Musculo-Skeletal System

☐ Hernia
☐ Muscle Weakness/ Aching
☐ Painful/ Stiff joints
☐ Back or Neck pain

Name: _____

Female patients

Last Mensural Period: _____ Number of pregnancy: _____ Deliveries: _____

Miscarriages: _____ Menopause: (Age): _____ ☐ N/A

☐Currently pregnant ☐Planning pregnancy

Previous Surgeries / Procedures / Hospitalizations

☐None

☐If so please list surgeries/procedures done and approximate dates done:

1)_____

2)_____

3)_____

4)_____

5)_____

Have you had complications from any surgeries or procedures? Y / N (If so please explain)

_____

_____

Medication

Please list all medications and strengths that are being taken at this time

1)_____ 6)_____

2)_____ 7)_____

3)_____ 8)_____

4)_____ 9)_____

5)_____ 10)_____

Allergies

Please list all allergies and reactions

☐ N/A

Allergy	***Reaction***
1)_____	_____
2)_____	_____
3)_____	_____

Name: _____

Past Medical History

Check all that apply

☐ Hypertension	☐ Diabetes	☐ High Cholesterol	☐ Heart Attack
☐ Cardiac Arrest	☐ Heart failure	☐ Atrial fibrillation	☐ Rheumatic fever
☐ Aneurysm of aorta	☐ Phlebitis	☐ Blood clot in lung	☐ Stoke
☐ Ulcer in stomach	(clot in vein)	☐ Ulcerative colitis	☐Diabetic eye problem
☐ Blood transfusion	☐ Asthma	(Crohn's Disease)	☐ Convulsions/Seizure
☐ Autoimmune disorder	☐ Gout	☐ Radiation Therapy	☐ Chemotherapy
☐ Gallbladder	☐ Pancreatitis	☐ Hepatitis/Liver disease	☐ HIV infection
☐ Kidney Disease	☐ Kidney Stones	☐ Osteoporosis	☐ Thyroid Disease

☐ Tuberculosis ☐ Other serious illnesses: _____

☐ Cancer (if so what kind):_____

Social History

☐Tobacco Use: ☐Current everyday ☐Current some days ☐Former smoker ☐Never

☐Alcohol Use: ☐Current everyday ☐Current some days ☐Socially

☐Drug Use: If so, what type and how frequent:_____

Do you live ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Other_____

Family Medical History

Relative	***Age, (if deceased at what age)***	***Medical Conditions***
Mother		
Father		
Siblings		
Children		