**PATIENT INFORMATION (please fill out completely):**

Patient Name: ________________________________________ Nickname/AKA: _________________________

Date of Birth: _____ / _____ / _____ Social Security #: ________________________ Sex: ____ M ____F

Home Address: _______________________________________________________________________________

City: ________________________________________ State: ______________ Zip Code: ________________

Home # ________________________ Cell # ________________________ Work # _______________________

How do you prefer we contact you with results and /or appointment reminders? (Must choose one)

Cell phone (Text) ______ Home Phone _______ Letter _______

Marital Status: Married ____ Single ____ Divorced ____ Separated ____ Widowed ____

Language(s) spoken : _________________________ Race: __________________ Hispanic Ethnicity? Y N

Do you need an interpreter? Y N Preferred Language: _______________________________________

Email address: _________________________________________ Employer: ____________________________

Spouse/Parent: ________________________________________ Phone: _______________________________

Emergency Contact: ___________________________________ Phone: _______________________________

How did you hear about Ohio Heart Group? _______________________________________________________

**<u>INSURANCE INFORMATION (Please fill out completely to insure correct billing)</u>**

Insurance name: __________________________________ Policy/Member ID#: __________________________

Patient's Relationship to insured: Self ____ Spouse ____ Child ____ Other _____

Policy Holder Name: ______________________________________ Employer: __________________________

Address: _______________________________________ City/State: ___________________________________

Zip: ______________ Phone #: ________________________________ Date of Birth: _____ / _____ / _____

## SECONDARY INSURANCE INFORMATION:

Insurance name: ________________________________ Policy/Member ID#: _________________________

Patient's Relationship to insured: Self ____ Spouse ____ Child ____ Other _____

Policy Holder Name: _____________________________________ Employer: _________________________

Address: _____________________________________ City/State: __________________________________

Zip: ______________ Phone #: _______________________________ Date of Birth: _____ / _____ / _____

Did you come to office via transportation service today? Y N

If so, transportation company name: ________________________________________________________

Transportation Company Phone #: ______________________________________

Do you require an American Sign Language Interpreter? Y N

## ASSIGNMENT OF BENEFITS:

The above information is true to the best of my knowledge.

- I authorize the physicians of Ohio Heart Group, Inc. to provide myself (or dependent) with reasonable and proper medical care.
- I authorize my Health Insurance Company or third party payer to pay my insurance benefits directly to Ohio Heart Group, Inc.
- I authorize Ohio Heart Group, to release any information required to process my insurance claim.
- I understand that I am ultimately financially responsible for any balance remaining on the account after insurance has paid or total charges even if the insurance is pending or has denied.

__________________________________________ __________________________

*Signature of Patient/Legal Guardian* *Date*

__________________________________________ __________________________

*Print Name* *Date of Birth*

**OHIO HEART GROUP**

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

Ohio Heart Group is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact Connie Grosh, Chief Operating Officer/Privacy Officer at 614-252-8300.

## USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating you health, diagnosing medical conditions, and providing treatment.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as from credit card companies that may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of the medical practice of University Cardiology, Inc. For example, information on services received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For exaMple, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization.

If you change your mind after authorizing a use or disclosure of your written information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified Ohio Heart Group, Inc of your decision to revoke your authorization.

## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Although your health record is the property of OHG, the information belongs to you. You have the following rights regarding your health information:

**Right to Inspect and Copy**. With some exceptions, you have the right to review and copy your PHI. You must file a written request with the office and your records will be made available to you in a reasonable period of time. There may be a fee for copying and mailing of such requests.

**Right to Amend**. If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information, and we may deny if no adequate reason is given. You have this right for as long as the information is kept by OHG.

**Patient privacy rights and policies are posted in their entirety for viewing in the lobby of each office.**

# PATIENT CONTACT AND DISCLOSURE PREFERENCES

**Patient Name (Print):__________________________Date of Birth: ___________**

I have read and understand the HIPPA/Notice of Privacy Policies for **Ohio Heart Group, Inc**. I have been given the opportunity to ask any questions I may have regarding the Notice of Privacy Policies for **Ohio Heart Group, Inc**.

## I wish to be contacted in the following manner: (please circle all that apply)

**Home Phone: ________________________________**

It is okay to leave a detailed message with medical information. Yes No
Leave a message with a call back number only. Yes No

**Cell Phone: _________________________________**

It is okay to leave a detailed message with medical information. Yes No
Leave a message with a call back number only. Yes No

**Work Phone: _________________________________**

It is okay to leave a detailed message with medical information. Yes No
Leave a message with a call back number only. Yes No

**Written Communication: (Please circle one)** Yes No

Who are we allowed to speak to about your health information: (This includes but not limited to, information regarding test, lab results, prescriptions and medical instructions, etc.

Name: _______________________ Relationship ________________PH#__________________

Name: _______________________ Relationship _______________PH#___________________

Please check if you prefer to have no one spoken to concerning your health information. ______

Patient's Signature_____________________________________ Date ______________________

**PATIENT PERSONAL MEDICAL HISTORY FORM**
**(Please answer all questions as completely and accurately as possible)**

**Name:** ______________________________________________ **Date of Birth** ______________________

**Reason for visit**:______________________________________ **PCP Dr.** ___________________________

### Do you have or have you been treated for: (Circle all that apply)

Chest Pain  Heart Attack  High Blood Pressure  High Cholesterol  Diabetes  Stroke  COPD

Carotid Disease  Heart Failure  Heart Valve Problem  Heart Murmur  Rheumatic Fever  Bronchitis

Heart Rhythm Problem  Vascular Disease  Asthma  Tuberculosis  Anemia  Blood Disorder

Stomach Ulcer  Heartburn/Reflux  Thyroid Problem  Kidney Disease  Gallbladder  Blood Clots

Hepatitis  Arthritis  Sleep Apnea  Seizures  Cancer date: __________ type: ___________________

**Other Medical Problems Not Mentioned Above :** ___________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

**Please List Surgeries: (Give location and date)**____________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

### Have you ever had any of the following heart tests/ surgeries? (Give location and date)

Cardiac Catheterization/ Stent ______________________  Stress Test ____________________________________________

Echocardiogram: _________________________________  Holter Monitor or Event Monitor (30 days):_____________________

Open Heart Surgery: ______________________________  Vascular Surgery/ Stents:___________________________________

Pacemaker/ Defibrillator Placement:__________________  Brand_____________________ Model Number________________

### Habits:

Do you smoke? ☐ Yes ☐No How many years? _______ Packs Daily: ______ Interested in quitting? ☐ Yes ☐No

Did you ever smoke? ☐ Yes ☐ No How many years? ________ Packs Daily: ______ When did you quit? _____________

How much alcohol do you drink? ______ day _________ week _____ month ______ year

Have you ever used any illegal drugs? If YES, when/how often/ last use________________________________________

How many caffeinated drinks do you drink? (Coffee, tea, soda) _____day _____week

Do you exercise? If YES, what/how often _____________________________________________________________

If you are a woman, have you passed menopause? Yes NO At what age? ______

Do you take estrogen replacement? YES NO

Are you taking birth control pills/IUD/ implant? YES NO

### Social History:

Marital Status: Single Married Widowed Divorced

Occupation:________________________________________________________________________________
_

Retired? YES NO

### Allergies:

Are you **allergic** to any medications? ☐ Yes ☐No, please list along with reaction: ______________________________

______________________________________________________________________________________________

**Circle any/all to which you are allergic:** IV Dye Adhesive Tape Iodine Latex Shell Fish

### Family History:

### Please note any family members with any of the listed conditions:

| | Living | Age | Heart Problem | High Blood Pressure | High Cholesterol | Stroke | Diabetes | Cancer |
|---|---|---|---|---|---|---|---|---|
| Father | ☐Y ☐N | _______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mother | ☐Y ☐N | _______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Brother(s) | ☐Y ☐N | _______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sister(s) | ☐Y ☐N | _______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Paternal Grandfather | ☐Y ☐N | _______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Paternal Grandmother | ☐Y ☐N | _______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Maternal Grandfather | ☐Y ☐N | _______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Maternal Grandmother | ☐Y ☐N | _______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Symptoms:**

**Please circle any symptoms you are having now or have had recently:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Constitutional: | Fever | Chills | Fatigue | Unexplained weight loss | Unexplained weight gain | |
| HEENT: | Blurred vision | Doubles vision | Blind Spots | Difficulty Hearing | Ringing in Ears | |
| Respiratory: | Shortness of Breath | Wheezing | Cough | Unusual Snoring | | |
| Gastrointestinal: | Heartburn | Diarrhea | Constipation | Black Stools | Nausea | Vomiting |
| Musculoskeletal: | Muscle Aches | Muscle Tenderness | Muscle Cramps | | | |
| Dermatological: | skin ulcers | rash | | | | |
| Neurological: | Dizziness | Headache | Passing out | | | |
| Hematological: | Bleeding | Easy Bruising | | | | |
| Psychiatric: | Anxiety | Depression | | | | |

**MEDICATIONS:**

**Please List All Your Current Medications with Dosing and Frequency** (Including Over the Counter Medications):

1.______________________________________________

2. ______________________________________________

3.______________________________________________

4.______________________________________________

5.______________________________________________

6.______________________________________________

7.______________________________________________

8.______________________________________________

9.______________________________________________

10.______________________________________________

11.______________________________________________

12.______________________________________________

13.______________________________________________

14.______________________________________________

**Medications (cont.)**

15.______________________________________________________________________

16.______________________________________________________________________

17.______________________________________________________________________

18.______________________________________________________________________

19.______________________________________________________________________

20.______________________________________________________________________

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**Pharmacy Name:** ____________________________________________________________________________

**Pharmacy Address:**___________________________________________________________________________

**Pharmacy Phone Number:** __________________________________________

**Patient's Signature:**________________________________________________________________

**Date Completed** ________________________

Thank you for providing this information to assist us in providing you with the best heart care!

**Ohio Heart Group**