



Ohio Heart Group

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? _____

INSURANCE INFORMATION (Please fill out completely to insure correct billing)

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	<input type="checkbox"/> Y <input type="checkbox"/> N _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/> Y <input type="checkbox"/> N _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s)	<input type="checkbox"/> Y <input type="checkbox"/> N _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s)	<input type="checkbox"/> Y <input type="checkbox"/> N _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal Grandfather	<input type="checkbox"/> Y <input type="checkbox"/> N _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal Grandmother	<input type="checkbox"/> Y <input type="checkbox"/> N _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Grandfather	<input type="checkbox"/> Y <input type="checkbox"/> N _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Grandmother	<input type="checkbox"/> Y <input type="checkbox"/> N _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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. _____

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