TEXAS HEART CENTER

DR. CARLOS VELASCO DR. ALFREDO JIMENEZ DR. PAUL AGGARWAL

DR. CARA EAST DR. PETER WELLS

WELCOME PACKET

YOUR APPOINTMENT HAS BEEN SCHEDULED ON: DATE: _____ TIME: _____

Should you need to cancel, please call the office at: 214-826-6044

Your appointment is scheduled at:
Texas Heart Center
Baylor University Medical Center
3600 Gaston Avenue
Suite 851, Wadley Tower
Dallas, Texas 75246

PLEASE READ THE BELOW LISTED INFORMATION

It is important that you bring any cardiology testing results you may have to your appointment. The physician needs this information to help you best at the time of your visit

If you are relying on the facility or another office to send these directly to our practice we ask you call 2 days in advance of your scheduled appointment to confirm that the office has received them.

Thank you for your cooperation and for choosing us to serve your health care needs

Every effort will be made to honor your appointment time.
Please note, however, that due to the nature of our practice, occasionally there are delays with appointments.
We apologize in advance for any inconvenience this may cause you.

Texas Heart Center

TYPE OF VISIT:
□ **New Patient** □ **Work Comp** □ **Auto** □ **Other**

DEMOGRAPHIC INFORMATION

Name: __ _____ **DOB:** ___/ ___ /_____ **AGE:** _____ **Social Security:** _____
Last First Middle Initial

Address:_____
Number Street City State Zip

Cell Phone: _____ Home Phone: _____ **EMAIL:** _____

Who referred you to our office? _____ Phone Number **:** _____

Who is your primary care doctor? _____ Phone Number **:** _____ Location: _____

Emergency Contact: _____ Phone Number **:** _____ Relationship: _____

ADDITIONAL INFORMATION

□ Male □ Female **Marital Status:** □ Married □ Single □ Other: _____

Race: □ Caucasian □ Black □ Hispanic □ Asian □ Native American □ Other
Ethnicity: □ Hispanic □ Non-Hispanic/Non-Latino □ Other/ Non-determined
Languages Spoken: □ English □ Spanish □ Other: _____

Occupation: _____ **Employer:** _____ **Phone:** _____

Does this visit pertain to a workers compensation injury or a personal injury? □ No □ Yes, If yes,

Date of Injury: _____ Claim #: _____ Adjuster Name: _____ Phone Number: _____

Is there a lawsuit planned, relating to your problem or injury, whether it be from a workers compensation claim or motor vehicle accident? **□ No □ Yes**

INSURANCE INFORMATION

Primary Insurance: _____**Subscriber ID #** _____ **Group #** _____
Primary Card Holder: □ Self *or* □ Spouse □ Parent □ Other: _____

Co-Pay: $_____ _____/_____
Name of Policy Holder Date of Birth of Policy Holder

Secondary Insurance: _____ **Subscriber ID #** _____ **Group #** _____
Secondary Card Holder: □ Self *or* □ Spouse □ Parent □ Other: _____

_____/_____
Name Of Policy Holder Date of Birth of Policy Holder

Besides regular mail, I authorize Texas Heart Center to contact me by the following methods: (please check boxes)
□ Cell phone □ Text messaging □ Home phone □ Email
DATE: _____ **SIGN: 1.** _____

Texas Heart Center

PATIENT NAME: _____ DATE: _____

RELEASE OF INFORMATION TO OTHERS (HIPPA)

I acknowledge that I have received a copy of "Notice of Privacy Practices". I authorize Texas Heart Center, and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, medical records and other health related items on my behalf.

What level of information can we release?

□ All information including specific medications and dosages, lab results and information related to sensitive issues such as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).

□ **No information whatsoever**

To whom can we release information (please list names):

□ _____
Name Phone# Relationship to Patient

□ _____
Name Phone# Relationship to Patient

□ **No one except the patient can obtain information.**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing that the revocation will not apply to information already released in response to this authorization.

2._____ _____
Signature of Patient/Guardian Date

TREATMENT CONSENT AND AUTHORIZATION

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment and is a means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill and a means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I hereby authorize Texas Heart Center to furnish to any designated attorney or insurance Company all information necessary to file a health insurance claim form, or to obtain reimbursement. *I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to Texas Heart Center.*

I understand that I am financially responsible for all charges whether paid or not paid by my insurance company. Also, I hereby authorize the disclosure of health information in any data format regarding my treatment during hospitalization and/or outpatient care to Texas Heart Center. I understand that this facility will maintain medical records in accordance with state requirements. By my signature below, you are fully authorized to disclose such information when requested by Texas Heart Center.

The foregoing information is true and correct to the best of my knowledge. I authorize Texas Heart Center to provide medical treatment to me in the office or in the hospital.

3._____ _____
Signature of Patient/Guardian Date

FINANCIAL AND GENERAL POLICY SIGNATURE

I have read and understand the Texas Heart Center Financial and General Office Policies. My signature indicates compliance and understanding of these policies and that I have completed all the forms to the best of my knowledge.

4._____ _____
Signature of Patient/Guardian Date

Texas Heart Center

PATIENT NAME: _____ DATE: _____

GENERAL CONSENT FORM LANGUAGE

I acknowledge that I am aware that one or more of the physicians providing my treatment at **Texas Heart Center** may have an ownership interest in Baylor Heart & Vascular Hospital (BHVH). I also acknowledge that I have the right to choose the provider of my healthcare services and have chosen
Dr. Peter J. Wells / Dr. Cara A. East / Dr. Paul Aggarwal / Dr. Carlos E. Velasco / Dr. Alfredo H. Jimenez.

_____
Initials

To further my commitment to the quality of surgical care for my patients, I have chosen to be an owner in Baylor Heart and Vascular Hospital. My ownership enhances my ability to direct the manner in which your care is delivered at the facility. If this is of concern to you, I will be happy to answer any questions. I am on the medical staff of other healthcare facilities and will be happy to discuss your option of choosing an alternative location.

Texas Heart Center

PATIENT NAME: _____ DATE: _____

REASON FOR VISIT

PLEASE TELL US THE REASON FOR YOUR VISIT: _____

_____

_____

PHARMACY INFORMATION

PREFERRED PHARMACY: _____ PHONE #: _____

PHARMACY ADDRESS**:** _____

MEDICATION ALLERGIES

□ **No Known Drug Allergies**

□ **No Other Allergies (latex, contrast or adhesives)**

□ **Yes I have known Drug Allergies (Please list name and symptoms)**

1._____ _____

2._____ _____

□ **Yes I have Other Allergies to things like latex, contrast or adhesives (Please list name and symptoms)**

1._____ _____

2._____ _____

CURRENT MEDICATIONS

LIST ALL THE CURRENT MEDICATIONS YOU ARE TAKING

NAME:	**DOSE**	**FREQUENCY**	**REASON PRESCRIBED:**
Example: Benadryl	*40 mg*	*one tab a day*	*Allergies*
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____

I understand that prescription refills should be handled at the time of the office visit whenever possible. It is my responsibility to know when my prescription is about to run out. A good rule of thumb is to always have at least a three day supply on hand. Medication refills are only handled during regular business hours and will not be addressed after business hours or on weekends.

6. _____ _____

Signature of Patient/Guardian Date

Texas Heart Center

PATIENT NAME: _____ DATE: _____

REVIEW OF SYSTEMS AND PAST FAMILY SOCIAL HISTORY

ROS. Does the patient currently have any of these issues? *Please circle yes or no*

Constitutional	Fatigue	No	Yes	Fever/Chills	No	Yes	Weight Loss/Gain	No	Yes
Neurologic	Seizures	No	Yes	Dizziness/Vertigo	No	Yes	Headaches	No	Yes
Musculoskeletal	Joint Pain	No	Yes	Back/Neck Pain	No	Yes	Morning Stiffness	No	Yes
Skin	Rash	No	Yes	Ulcers/Lesions	No	Yes			
Pulmonary	Short of Breath	No	Yes	Wheezing	No	Yes	Cough	No	Yes
Cardiology	Chest Pain	No	Yes	Palpitations	No	Yes	Irregular Heart Beat	No	Yes
	Swelling	No	Yes						
Gastrointestinal	Diarrhea	No	Yes	Nausea/Vomiting	No	Yes	Abd Pain/Blood in Stool	No	Yes
Genitourinary	Freq Urine	No	Yes	Pain Urinating	No	Yes	Burning with Urination	No	Yes
Eyes/Ears/Nose	Nasal Drainage	No	Yes	Change of Vision	No	Yes	Loss Of Hearing	No	Yes
Mouth and Throat	Sore Throat	No	Yes	Tooth Ache	No	Yes		No	Yes
Hematologic	Easy Bleeding	No	Yes	Easy Bruising	No	Yes			
Psychiatric	Anxiety	No	Yes	Depression	No	Yes			

If you checked yes to any of the above, are you under treatment for this issue with a physician? No Yes

If so, who is the physician treating you? _____

FAMILY AND SOCIAL HISTORY

□ **Married** □ **Single** □**Children**_____ □ **Height**_____ □ **Weight**_____

Alcohol Intake: Please circle the one that applies to you:

Never Drink Drink Occasionally Drink Daily

Please circle what you drink:

Wine Beer Liquor

Do any Family Members Have an Alcohol History? □ Yes □ No

Smoking History: Do you smoke currently? □ Yes □ No How long? _____ How Many? ____ packs/day

Are you a former smoker? □ Yes □ No When did you quit? ____

How many years did you smoke? _____years

Blood Products/Transfusions:

Do you have any objections to receiving blood or blood products? □ **No** □ **Yes**

Drug Usage:

Do you now or have you ever used drugs? □ **No** □ **Yes**

If yes, please explain: _____

Texas Heart Center

PATIENT NAME: _____ DATE: _____

PAST MEDICAL AND PAST FAMILY SOCIAL HISTORY

PFSH: Has the patient or family member ever been diagnosed with any of the following medical conditions?

	FAMILY MEMBERS	PATIENT	IF YES FOR PATIENT, PLEASE EXPLAIN
Heart Disease (CAD)	No Yes	No Yes	
Diabetes	No Yes	No Yes	
Stroke	No Yes	No Yes	
Cancer	No Yes	No Yes	
Coagulation Defects		No Yes	
DVT (Blood Clots) in legs		No Yes	
Anemia		No Yes	
Hepatitis / HIV		No Yes	
High Blood Pressure		No Yes	
Kidney Disease		No Yes	
Lung Disease or Asthma		No Yes	
Sleep Apnea		No Yes	
Stomach Ulcers		No Yes	
Colitis		No Yes	
Rheumatoid /Osteoarthritis		No Yes	
Lupus		No Yes	
Epilepsy or History of Seizures		No Yes	
Depression /Anxiety Disorders		No Yes	

If you checked yes to any of the above, are you under treatment for this issue with a physician? □ **No** □ **Yes**

If so, who is the physician treating you? _____

OTHER HEALTH RELATED ISSUES NOT COVERED ABOVE

_____

_____

PRIOR SURGERIES

Please list any surgeries you have had:

□ _____ □ _____

□ _____ □ _____

□ _____ □ _____

□ _____ □ _____

□ _____ □ _____

PRIOR HOSPITALIZATIONS

Please list any hospitalizations you have had:

□ _____ □ _____

□ _____ □ _____

□ _____ □ _____

□ _____ □ _____

□ _____ □ _____

PHYSICIAN ONLY

I have reviewed the listed ROS/PFSH/Screening with the patient and noted the positive/negative findings for this visit.

SIGNATURE OF MD: _____ **DATE:** _____