# TEXAS HEART CENTER

DR. CARLOS VELASCO DR. PAUL AGGARWAL

# WELCOME PACKET

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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*

## 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 **:** _____ Fax: _____
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

**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. Melissa M. Carry / 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.

*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

**Have you received your covid-19 vaccines?_____If so, on what dates did you receive your vaccines?_____ & _____**

**□ Married □ Single □Children_____ □ Height_____ □ Weight_____**

**Occupation:** _____

**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:** _____