Effective 11/20/2019

Dear patients,

Our office is commited to providing quality medical care that emphasizes patient safety. Safe and accurate use of your medications is an important part of your health care.

Our Goals Include:

- **To encourage and educate patients in safe and correct use of their medications.**
- **To reduce medication errors, interactions, and side effects**
- **To improve care coordination of medication prescribing and use.**

Key Medication safety points we would like you to follow include:

- **Bring in ALL medications to each visit.**
  Your Physician and staff will review your medications at each visit, having the actual prescription bottles will ensure that the medication and dosage are the correct ones. This can only be done is we have the actual prescription bottles available.

- **Keep medication in its original labeled bottle.**
  For your safety, please keep your new or refill medications in the containers they came in from the pharmacy. Do not combine medication with older pills. Please discard old or unused bottles to avoid confusion.

- **Dispose of all outdated medication, medication bottles, and medication you no longer use.**
  If you are instructed by your physician to keep a medication you are not currently taking, clearly mark and seal the bottle to avoid taking it by mistake.

- **Bring all of your medication to consultant physician appointments, hospitals, emergency rooms, and urgent care centers.**
  Providing a list of your medications to other physicians, hospitals, and emergency rooms, will reduce the risk of duplicating medications, drug interactions, and allergies.

Thank you,

Heart MD, LLC
478-257-5533

Demographic Information:

Patient Name:_____ DOB:____/____/_____ SS#_____-_____-_____

Mailing Address:_____

City:_____State:_____Zip:_____

Home Phone:(_____)_____-_____Cell Phone:(_____)_____-_____ Do you have texting capability? Y / N

Email Address:_____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number_____

Primary Care Physician:(Please specify physician's name, not place of practice)_____

Pharmacy:_____Pharmacy Location:_____

Employment Status:

- ☐ Full Time _____
- ☐ Part Time
- ☐ Unemployed
- ☐ Disabled
- ☐ Retired

Policy Holder:

- ☐ Self
- ☐ Spouse
- ☐ Parents

Marital Status:

- ☐ Married
- ☐ Single
- ☐ Divorced

Ethnicity:

- ☐ Non-Hispanic
- ☐ Hispanic/Latino
- ☐ Refused to report

Race:

- ☐ White
- ☐ African American
- ☐ Asian
- ☐ Other

Insurance Information:

Primary Insurance:_____

Policy Number:_____Group Number:_____

If Policy is under anyone other than the patient:

Guarantor Name:_____ DOB:_____

SS#_____

Secondary Insurance:_____

Policy Number:_____Group Number:_____

If Policy is under anyone other than the patient:

Guarantor Name:_____ DOB:_____

SS#_____

Medical Record Release Form

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

Patient Address:

Street: _____

City: _____ **State:** ____

Zipcode: _____

Requesting records from: _____

I hereby request and authorize the release of my entire medical records file for the purpose of continuation of care, to Heart MD, LLC. Please fax all records to 478-347-3115. Thank you.

Patient Signature: _____

Date: _____

Patient Name: _____ DOB: _____ Today's Date: _____

Reason for your visit today: _____

Symptoms: Please circle all that apply

- Chills / Fatigue / Headache / Lighthededness
- Chest pain now / Cough / Coughing up blood / Shortness of breath on exertion / Wheezing
- Chest pain on exertion / Dizziness / Weakness Shortness of breath when sleeping flat / Palpitations / Shortness of breath / Chest pain at rest
- Constipation / Diarrhea / Heartburn / Nausea / Vomiting / Joint Stiffness / Leg pain or cramps / Muscle aches / Leg swelling

Prior Heart Problems: Only mark the ones that apply

- ☐ Recent Hospitalization, Where? _____
- ☐ Heart Attack, When? _____
- ☐ Cardiac Cath, When? _____
  Where? _____
- ☐ Angioplasty, When? _____
- ☐ Stent, When? _____
- ☐ Open Heart Surgery, When? _____
- ☐ Pacemaker or AICD
- ☐ Enlarged Heart
- ☐ Congestive Heart Failure (CHF)
- ☐ Abnormal Stress Test
- ☐ Abnormal EKG
- ☐ Aortic Stenosis/ Mitral Valve Prolapse
- ☐ Rheumatic Fever

Past Surgical History:

_____

_____

_____

Medical History: Mark only the ones that apply

- ☐ Diabetes (High Blood Sugar)
  (Type I) (Type 2)
- ☐ Insulin (shots) or oral meds (pills)
- ☐ Lung Disease (asthma, emphysema, bronchitis)
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Cancer (any type)

Social History: Only circle the ones that apply

Smoker: Former Current Never

When did you quit? _____

How many packs do you smoke a day? _____

Alcohol Usage: Occasional Frequent

Exercise: None Very Little 3 or more times/wk

- ☐ Require Assistance Walking

Females:

- ☐ Possibility of Pregnancy
- ☐ Currently Breastfeeding

Family (Blood) History: Only mark the ones that apply

Please specify paternal or maternal

- ☐ Any relative have a heart attack? What age?
  _____
  _____
- ☐ Any relative have sudden cardiac death? What age?
  _____
- ☐ Any relative with heart problems? Who?
  _____
  _____

Compound Authorization for Release of Information:

Patient Name:_____DOB:_____/_____/_____

I hereby release all medical information to the following:

1.) Name:_____
Relationship:_____
Contact Number:_____

2.) Name:_____
Relationship:_____
Contact Number:_____

3.) Name:_____
Relationship:_____
Contact Number:_____

4.) Name:_____
Relationship:_____
Contact Number:_____

Identity theft prevention policy: I hereby acknowledge that I have provided Heart MD with my correct proof of identification. I am also aware that they can ask me at any visit for my photo ID and current health insurance card. By signing this form, I certify that I have read, fully understand, and will comply with this policy.

Authorization for release of information and consent to treat: I authorize Heart MD, LLC. to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable disease) requested by my health insurance carrier, Medicare, or any other third-party payers. I authorize Heart MD, LLC. to release all medical information to my referring and primary care physician. I authorize Heart MD, LLC. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health care plan administrator to release such information to Heart MD, LLC. I agree that these provisions will remain in effect until I provide written revocation to Heart MD, LLC. I or my legal guardian authorizes Heart MD, LLC to provide medical care reasonable by today's standards.

Notice of Privacy Practices: I understand that there are copies of the Heart MD, LLC.'s Notice of Privacy Practices, available for my use, both at the front desk and posted in the lobby.

Signature of Patient or Legal Guardian:_____Date:_____