Patient Questionnaire

First Name:______________________ Middle Initial:_____ Last Name:_______________________________

Date of Birth:_________________________ Age:______________ Male ☐ Female ☐

Mailing Address: ____

City:____________________ State:_____ Zip:__________ Home Phone:( )_______________________

Daytime Phone:( )______________________ Mobile Phone:( )_________________________________

Social Sec. #:______________________________ Married ☐ Single ☐ Widow ☐

Spouse's First Name:____________________ Middle Initial:_____ Last Name:_________________________

Spouse's Social Sec. #:_______________________ Daytime Phone:( )_______________________________

Emergency Contact and Relationship:____

Emergency Phone:( )______________________ Referring Physician:______________________________

Please list all doctors you see:

Doctor's Name	Type of Doctor	Reason for Seeing

Briefly describe your reason for consulting a heart doctor today:

____

Current Allergies:

Do you have ALLERGIES TO IODINE, seafood or radiographic contrast dye? ☐ **YES** ☐ **NO**

Please list any other allergies and describe the reaction:

Allergy to:	Reaction:

If more space is needed, you can use the bottom of the last page of this form.

Current Medications:

♥Remember to bring all medications with you at time of appointment

Please list all medications (prescription and non-prescription) that you are now taking or occasionally take:

Medication Name	Dosage	How Often Taken?	Who prescribed?

Past Medical History:

Please check if you had any of the following problems in the past:

Heart Attack?	_____	Congestive Heart Failure?	_____
Blackouts or Fainting spells?	_____	High blood pressure?	_____
Frequent dizzy spells?	_____	Rheumatic Heart Disease?	_____
Blood clots in veins or legs?	_____	Infection in the heart?	_____
Abnormal EKG?	_____	Blood clots in lungs or legs?	_____
Palpitations, skips, or irregular heartbeat?	_____	Abnormal heart rhythms?	_____
Pain in the arms, throat, jaw or upper back?	_____	Chest Pain, pressure, or tightness?	_____

Past Cardiac Procedures or Tests:	Date	Location	Physician
Heart Catheterization (dye test)	__________	__________________	_________________
Heart Surgery (bypass, valve replacement)?	__________	__________________	_________________
Other blood vessel surgery?	__________	__________________	_________________
Electrophysiology Study?	__________	__________________	_________________
Pacemaker or AICD Implantation?	__________	__________________	_________________
Echocardiogram?	__________	__________________	_________________
Stress Test (Treadmill, etc.)?	__________	__________________	_________________
Holter Monitor?	__________	__________________	_________________

Past Medical Illnesses:

Please list any serious illness for which you have been hospitalized (except admissions just for surgery)

____

Past Surgeries:

Please provide the year for all that apply

Gallbladder _____________ Tonsillectomy _____________ Appendix ______________

Hysterectomy ___________ Prostate __________________ Hernia _________________

Breast biopsy or mastectomy ________________ Other operations:_____________________

Social History and Lifestyle:

Do you drink alcohol?☐ YES ☐ NO If YES, How many drinks on an average day? ________

Do you currently smoke? ☐ YES ☐ NO If YES, How much do you smoke? _________________

How long have you been smoking? ________ If you quit smoking, when did you quit? ________

How many packs a day did you smoke? ______ How many years did you smoke before quitting? _______

Are you on a special diet? ☐ YES ☐ NO If YES, What type if diet? _____________________

How many cups of caffeinated beverages do you drink on an average day? ________

Do you exercise on a regular basis? ☐ YES ☐ NO If YES, What type of exercising and how often? ________

____

Do you have a history of drug dependency? ☐ YES ☐ NO If YES, Specify: ___________________________

Place of Birth: ____________________ Religion: ________________

Education (highest level): _____________ Occupation: _____________ Hours Worked per Week: __________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse Occupation: ________________

Do you live: ☐ Alone ☐ With Spouse ☐ Children ☐ Other

Family History: Please list any brothers, sisters, parents, or children who have had heart attack, stroke, angioplasty, heart disease, cardiac arrest, blackout spells.

Relationship:______________________ Condition:__________________________ at what age:____ Deceased: Y N

Relationship:______________________ Condition:__________________________ at what age:____ Deceased: Y N

Relationship:______________________ Condition:__________________________ at what age:____ Deceased: Y N

Review of Systems:

Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.

General:

Decreased exercise tolerance?	☐ YES	☐ NO	________________________
Fatigue?	☐ YES	☐ NO	________________________
Weight change? ☐ Gain ☐ Loss	☐ YES	☐ NO	________________________
Change in Appetite?	☐ YES	☐ NO	________________________

Integumentary (Skin):

Changes in moles?	☐ YES	☐ NO	________________________
Rash?	☐ YES	☐ NO	________________________
Itching?	☐ YES	☐ NO	________________________
Changes in hair?	☐ YES	☐ NO	________________________
Changes in nails?	☐ YES	☐ NO	________________________

Eyes:

Do you wear glasses/contact lenses?	☐ YES	☐ NO	________________________
Do you have blurred vision?	☐ YES	☐ NO	________________________
Do you experience double vision?	☐ YES	☐ NO	________________________
Do you have a history of cataracts?	☐ YES	☐ NO	________________________
Glaucoma?	☐ YES	☐ NO	________________________

Ear, Nose, Mouth and Throat:

Do you have a hearing deficit?	☐ YES	☐ NO	________________________
Do you wear dentures/braces?	☐ YES	☐ NO	________________________
Chronic sinus problems?	☐ YES	☐ NO	________________________
Do you have nose bleeds?	☐ YES	☐ NO	________________________
Hoarseness/Changes in voice?	☐ YES	☐ NO	________________________

Respiratory:

Do you wheeze?	☐ YES	☐ NO	________________________
Do you have a chronic cough?	☐ YES	☐ NO	________________________
Have you coughed up blood?	☐ YES	☐ NO	________________________
Do you experience shortness of breath?	☐ YES	☐ NO	________________________
☐ At rest? ☐ With activity?			
Do you snore?	☐ YES	☐ NO	________________________

Cardiovascular:

Chest pain, pressure or tightness?	☐ YES	☐ NO	________________________
☐ At rest? ☐ With activity?			
Heart palpitations (racing)?	☐ YES	☐ NO	________________________
Irregular heart beats?	☐ YES	☐ NO	________________________
Short of breath lying flat?	☐ YES	☐ NO	________________________
Waking up panicky, short of breath?	☐ YES	☐ NO	________________________
Have you passed out?	☐ YES	☐ NO	________________________
Swelling of feet or ankles?	☐ YES	☐ NO	________________________
Pain in legs with walking?	☐ YES	☐ NO	________________________

Gastrointestinal System:

Frequent nausea?	☐ YES	☐ NO	________
Frequent vomiting?	☐ YES	☐ NO	________
Abdominal pain?	☐ YES	☐ NO	________
Black, tarry stool?	☐ YES	☐ NO	________
Bright red blood in stool?	☐ YES	☐ NO	________
History of stomach ulcers?	☐ YES	☐ NO	________
Frequent diarrhea?	☐ YES	☐ NO	________
History of gallbladder problems?	☐ YES	☐ NO	________
History of liver problems?	☐ YES	☐ NO	________

Genitourinary:

Do you have pain with urination?	☐ YES	☐ NO	________
Sense of urgency to urinate?	☐ YES	☐ NO	________
Awaken frequently to urinate?	☐ YES	☐ NO	________
History of bladder, kidney infection?	☐ YES	☐ NO	________
History of kidney stone?	☐ YES	☐ NO	________
Males: Prostate problems?	☐ YES	☐ NO	________
Females: Post menopausal?	☐ YES	☐ NO	________
Currently taking hormone replacement?	☐ YES	☐ NO	________

Musculoskeletal:

Chronic back pain?	☐ YES	☐ NO	________
Arthritis?	☐ YES	☐ NO	________
History of gout?	☐ YES	☐ NO	________
Joint pain or stiffness	☐ YES	☐ NO	________
Muscle pain or cramps?	☐ YES	☐ NO	________
Muscle weakness?	☐ YES	☐ NO	________
History of blood clots in legs?	☐ YES	☐ NO	________
History of varicose veins?	☐ YES	☐ NO	________

Neurological:

Temporary blurred vision/loss of vision?	☐ YES	☐ NO	________
Temporary weakness and/or tingling involving an arm or leg?	☐ YES	☐ NO	________
Severe headaches?	☐ YES	☐ NO	________
Migraine headaches?	☐ YES	☐ NO	________
Convulsions/Seizures?	☐ YES	☐ NO	________

Psychiatric:

History of depression?	☐ YES	☐ NO	________
Chronic Anxiety?	☐ YES	☐ NO	________
Stress at work or home?	☐ YES	☐ NO	________
History of drug or alcohol abuse?	☐ YES	☐ NO	________
Trouble sleeping?	☐ YES	☐ NO	________
Thoughts of suicide?	☐ YES	☐ NO	________

Endocrine:

Fatigue?	☐ YES	☐ NO	________
High cholesterol?	☐ YES	☐ NO	________
Diabetes?	☐ YES	☐ NO	________
Thyroid problems?	☐ YES	☐ NO	________

Hematological/Immunologic:

Chronic low blood count/anemia?	☐ YES	☐ NO	______________________
Bleeding problems?	☐ YES	☐ NO	______________________
Seasonal allergies?	☐ YES	☐ NO	______________________
Food allergies?	☐ YES	☐ NO	______________________

Thank you. Again, please be sure to bring all your medicines to each visit with us.

FINANCIAL POLICY

All Co-payments are due at check in for your appointments.

Thank you for choosing Heart Clinic Arkansas as your health care provider. We are committed to providing excellent health care services to our patients! As part of our professional relationship, we encourage you to read our financial policy and ask that you acknowledge your understanding by signing below.

FINANCIAL RESPONSIBILITY

The patient (or designated responsible party) has full financial responsibility for **all** charges for services provided. We gladly file insurance claims as a courtesy but this does not relieve the financial responsibility of those charges from the patient and we do not guarantee all charges are covered by the patient's insurance plan or payment will be received from the insurance carrier. **Your insurance co-pay is due at check in for your appointments.** Contact your insurance carrier if you have questions regarding your insurance coverage, deductible or co-pay. Heart Clinic Arkansas physicians are participating providers with most major insurance carriers, Medicare and Arkansas Medicaid and are required to comply with our contractual obligations. **It is unlawful to waive co-pays, deductibles or co-insurance amounts.**

INSURANCE AND PATIENT / BILLING INFORMATION

In order to accurately and timely file an insurance claim or notify the patient regarding any insurance or medical issues, we will routinely update this information upon return visits. **It is the patient's responsibility to provide accurate insurance and patient / billing information.** Please be prepared to bring insurance card(s) to each appointment and let our staff know when there has been a change in the patient or responsible party information. **Please note- if we fail to receive payment or notice from the insurance company we have on file within 60 days of submitting the claim, the entire balance will become due from the patient.**

OPTIONS FOR PAYMENT

We accept all major credit cards, cash or check. We also offer online bill pay through our website at www.heartclinicarkansas.com under Patient Information. Assistance is available for qualified individuals with financial hardship or lack of insurance coverage.

PAYMENT PLANS AND DELINQUENT ACCOUNTS

As a courtesy to our patients, **we allow 90 days for payment of balances** after insurance has paid its portion of those charges and contractual adjustments have been made. **In some instances, a short term payment plan may be available and arranged through our Heart Clinic Arkansas Financial Consultants. However, as we are not a financial institution, any balance remaining will be transferred to a collection agency. Collection fees may be charged to you.** Heart Clinic Arkansas is not able to service lengthy financial arrangements and follow up on delinquent accounts. We care about our patient's financial needs and the collection agency is equipped to work with our patients on successful payment of account balances with terms extending beyond what we can offer at Heart Clinic Arkansas.

INSUFFICIENT FUNDS

A $30 insufficient fund charge will be added to the patient balance for any returned checks or reversed debit or credit card charges from our bank.

HEART CLINIC ARKANSAS CONTACT INFORMATION

Contact our billing office at 501-255-6003 or for added convenience email at billing@heartclinicarkansas.com.

ACKNOWLEDGEMENT:

______________________________	____________________	__________
Signature of Responsible Party	Print Name	Date

____
Print Patient Name If Not Responsible Party

Heart Clinic Arkansas
10100 Kanis Road
Little Rock, AR 72205

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Heart Clinic Arkansas Privacy Officer at 501-255-6000.

WHO WILL FOLLOW THIS NOTICE

This notice describes our office's practices and that of all healthcare professionals, employees and staff.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about our patients is personal. We are committed to protecting medical information about our patients. We create a record of the care and services you receive in our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our office.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other medical personnel who are involved in taking care of you at the hospital. For example, a doctor treating you may need to know if you have diabetes because diabetes may slow the healing process. We also may share medical information about you with other healthcare providers who are treating your medical conditions in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received at our office so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Healthcare Operations. We may use and disclose medical information about you for healthcare operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other physician offices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study healthcare and healthcare delivery without learning who the specific patients are.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at our office. We may leave messages on your answering machine about appointments unless you tell us not to do so.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Communication With Family. Healthcare professionals, using their best judgment, may disclose to a family member, a close personal friend or any other person you identify, health information needed for that person to be involved in your care or payment related to your care.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. As required by law, we may disclose medical information about you to authorities charged with preventing or controlling disease or disability.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made by the person seeking your records to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time and we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you in accordance with our Clinic Policies.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Obtain a Copy. You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and obtain a copy of medical information that may be used to make decisions about you, you must submit your request in writing to *Heart Clinic Arkansas, Attention: Privacy Officer, 10100 Kanis Road, Little Rock, AR 72205.* If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by our office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Clinic.

To request an amendment, your request must be made in writing and submitted to the *Heart Clinic Arkansas, Attention: Privacy Officer, 10100 Kanis Road, Little Rock, AR 72205.* In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for our office;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of some of the disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to *Heart Clinic Arkansas, Attention: Privacy Officer, 10100 Kanis Road, Little Rock, AR 72205.* Your request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a particular type of treatment you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our office's Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, inquire at the reception desk.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. The notice will contain the effective date. In addition, each time you register for treatment or healthcare services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact *Heart Clinic Arkansas, Attention: Privacy Officer, 10100 Kanis Road, Little Rock, AR 72205.* All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

EFFECTIVE DATE: APRIL 14, 2003