



Patient Information Sheet

Last Name	F:	irst Name			MI
Street Address		City		St	Zip
Cell Number	HomeNumber_		—Email——		
Primary Care Physician		Referring Phys	ician		
Date of Birth	MaleFemale	Marital Status:(C	ircle) Marrie	d, Divorce	d, Single, Widow
SS#	Advance Directive		Yes or No		
	I	nsurance	;		
Insurance Company	Phone Number				
Subscriber #	Group #				
Copay	Deductible		Cov	Coverage%	
Policy Holders Name Pa	rty (if not self)				
Last Name	Fi	rst Name			Mi
Street Address		City		St	Zip
Date of Birth	SS#		Relation		
	Second	lary Insu	rance		
Insurance Company	Phone Number				
Subscriber #	Group #				
Copay	Deductible		Coverage%		
Policy Holders Name Par	ty (if not self)				
Last Name	First Name		Mi		
Street Address		City		St	Zip
Date of Birth	SS#		Relation		



Patient NameD	OBDATE
Your Concerns	
Home Medications:	Allergies:
List All Medications & Dosages Your Are Presently Taking and How Frequently You Take Them.	
Medication / Dose / Frequency	
Past Medical History (Please Circle and add detail)	
Anemia	Syncope
Asthma	Dementia
Aneurysm	Cancer
Arthritis	Skin Cancer
Atrial Fibrillation	COPD
Atrial Flutter	Pulmonary Artery Hypertension
Coronary Artery Disease	Pleurisy
Congestive Heart Failure	Pulmonary Embolism
Heart Block	Tuberculosis
SVT	Sleep Apnea
rregular Heart Rate	Connective Tissue Disease
VII (Heart Attack)	Diabetes
Murmur	Dialysis
Valvular Prolapse	Renal Failure
/alvular Heart Disease	Gastrointestinal Bleed_
Hypertension	GERD
Cellulitis	Peptic Ulcer
Claudication	Diverticulitis
Deep Vain Thrombosis	Liver Disorder
Phlebitis	Thyroid Disorder
Peripheral Vascular Disease	Linid Disorder
CVA	Lipid DisorderRheumatic Fever
Seizure Disorder	Back Pain



Surgical History (Please list Date/ Facility/ Doctor)	Please List Other Surgeries
Abdominal Surgery	
Amputation	
Aneurysm Repair	
Aortic Value Replacement	
Appendectomy	
Arteriogram	
Leg Bypass Left/ Right	
CABG Open Heart	<u> </u>
Endarterectomy Left/Right	
Electrophysiology Study	
Gallbladder Surgery	
IVC Filter	
Heart Cath	
Mitral Value Replacement / Repair	
Pacemaker	
PTCA (Stents)	
Thyroid Surgery	
Surgical Complications	
Family History (Please Circle)	
railing ristory (Please Circle)	
Aortic Aneurysm	[Father Mother Sibling Grandparent]
Asthma	
AsthmaCancer	[Father Mother Sibling Grandparent] [Father Mother Sibling Grandparent]
AsthmaCancerCongestive Heart Failure	[Father Mother Sibling Grandparent] [Father Mother Sibling Grandparent] [Father Mother Sibling Grandparent]
AsthmaCancerCongestive Heart FailureConnective tissue Disease	[Father Mother Sibling Grandparent] [Father Mother Sibling Grandparent] [Father Mother Sibling Grandparent] [Father Mother Sibling Grandparent]
AsthmaCancerCongestive Heart FailureConnective tissue Disease	[Father Mother Sibling Grandparent]
AsthmaCancerCongestive Heart FailureConnective tissue DiseaseCoronary Artery DiseaseCoronary Heart Disease male < 55	[Father Mother Sibling Grandparent] [Father Sibling Grandparent]
Asthma Cancer Congestive Heart Failure Connective tissue Disease Coronary Artery Disease Coronary Heart Disease male < 55 Coronary Heart Disease Female < 55	[Father Mother Sibling Grandparent] [Father Sibling Grandparent] [Mother Sibling Grandparent]
AsthmaCancerCongestive Heart FailureConnective tissue DiseaseCoronary Artery Disease	[Father Mother Sibling Grandparent] [Father Sibling Grandparent] [Mother Sibling Grandparent] [Father Mother Sibling Grandparent]
AsthmaCancerCongestive Heart FailureConnective tissue DiseaseCoronary Artery DiseaseCoronary Heart Disease male < 55Coronary Heart Disease Female < 55CVA or Stroke	[Father Mother Sibling Grandparent] [Father Sibling Grandparent] [Mother Sibling Grandparent] [Father Mother Sibling Grandparent] [Father Mother Sibling Grandparent]
Asthma Cancer Congestive Heart Failure Connective tissue Disease Coronary Artery Disease Coronary Heart Disease male < 55 Coronary Heart Disease Female < 55 CVA or Stroke Diabetes Cholesterol Problems	[Father Mother Sibling Grandparent] [Father Sibling Grandparent] [Mother Sibling Grandparent] [Father Mother Sibling Grandparent] [Father Mother Sibling Grandparent]
Asthma Cancer Congestive Heart Failure Connective tissue Disease Coronary Artery Disease Coronary Heart Disease male < 55 Coronary Heart Disease Female < 55 CVA or Stroke Diabetes Cholesterol Problems Hypertention	[Father Mother Sibling Grandparent] [Father Sibling Grandparent] [Mother Sibling Grandparent] [Father Mother Sibling Grandparent]
Asthma Cancer Congestive Heart Failure Connective tissue Disease Coronary Artery Disease Coronary Heart Disease male < 55 Coronary Heart Disease Female < 55 CVA or Stroke Diabetes Cholesterol Problems Hypertention Marfan's Syndrome	[Father Mother Sibling Grandparent] [Father Sibling Grandparent] [Mother Sibling Grandparent] [Father Mother Sibling Grandparent]
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Asthma Cancer Congestive Heart Failure Connective tissue Disease Coronary Artery Disease Coronary Heart Disease male < 55 Coronary Heart Disease Female < 55 CVA or Stroke Diabetes Cholesterol Problems Hypertention Marfan's Syndrome Pulmonary Hypertension Perípheral Vascular Disease	[Father Mother Sibling Grandparent] [Father Sibling Grandparent] [Mother Sibling Grandparent] [Father Mother Sibling Grandparent]
Asthma Cancer Congestive Heart Failure Connective tissue Disease Coronary Artery Disease Coronary Heart Disease male < 55 Coronary Heart Disease Female < 55 CVA or Stroke Diabetes Cholesterol Problems Hypertention Marfan's Syndrome Pulmonary Hypertension Peripheral Vascular Disease Prolong QT	[Father Mother Sibling Grandparent] [Father Sibling Grandparent] [Mother Sibling Grandparent] [Father Mother Sibling Grandparent]
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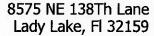


Social History	Social History		Drug use:	Drug use:		
Marital status: Sin	ngle, Married, Divor	ced, Widowed	I use one of the following o	drugs:		
What is/was your Occupation		Marijuana, Cocaine, Crack, Heroin, Illicit Prescription				
Disabled			Other			
			I do not use drugs:			
Smoking History:			Special Diet:			
Current Smoker:			Are you on a special diet :			
Number of y	ears		Calorie Limited	Low Salt		
Cigarettes	packs p	oer day	Low Fat	Diabetic		
Cigars:	numbe	er per week	High Fiber	Low Cholesterol		
Smokeless amount per day		I am not on a special diet:				
Would you li	ke counseled to quit	t Yes / No	Exercise :	Exercise :		
Former Smoker:			Do you follow and exercise program:			
Year Quit			How may time a week			
Never Smoker:			Type of Exercise_		<u> </u>	
			I do not follow and exercise	e program		
Review of Sympto	ms (Please circle if y	you have any of the following)	Gastrointestinal			
Respiratory			_ Abdominal Pain Constipation	Blood In Stool Diarrhea	Change in bowel Heartburn	
Chest conges	tion Cough	Dyspnea	Nausea		Ticareau	
Hemoptysis		Pain with breathing				
Shortness of	Breath	Wheezing	Hematologic Abnormal Bleeding Easy Bru		Easy Bruising	
Cardiovascular					,	
Chest Pain	Claudication	Cold Extremities	Musculoskeletal			
Dizzîness	Fainting	Fatigue	Joint Pain	Joint Stiffness	Leg Cramps	
High Blood Pr	-	Irregular Heart Beat	Muscle Aches			
Leg Edema	Lightheadedne	ss Near Syncope	Novemberieni			
			Neurological Confusion	Haadaahaa	Incoordination	
Constitutional			Numbness	Headaches Seizures	Tremor	
Fatigue Weight Loss	Fever	Weight Gain	Weakness	Jeizures	Tremoi	
Endocrine			Psychosocial			
Cold Tolerand	ce Polydipsia	Polyuria	Anxiety	Depression	Insomnia	
ENT						
Allergies	Nasal Congestion	on Post Nasal Drip	Urologic			
Ringing in Ear	s Sore Throat		Dysuria	Hematuria	Nocturia	



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Nam	ne:	Date of Birth:	
Previous Nam	ne:	Last Four digits S	s
I request and	d authorize the following health o	are providers to release healt	thcare information of the patient named abov
Provider Nam	ne	PH	FX
	ne		FX
Provider Nar	me	PH	FX
Record rele	ease from all of the following Hos		Marion, Advent Health Ocala, Leesburg ges Regional and Watermen Hospital.
Release To			
Name: Village	e Heart and Vein		
Address: 857	5 NE 138th Lane		
Lady Lake FI.	32159		
Ph 352-674-2	2080		
Fax 352-674-	2178		
Please send t		are information relating to Ca e. Last Progress note and all (ardiology , Electrophysiologist or Peripheral Cardiac Testing
simplex, hum chancroid, ly		wart, condyloma, Chlamydia, (Human Immunodeficiency \	0.24 et seq., includes herpes, herpes non-specific urethritis, syphilis, VDRL, /irus), AIDS (Acquired
☐ Yes ☐ No	the person(s) listed above.	I understand that the person	ing, whether negative or positive, to (s) listed above will be notified that I f these test results to anyone.
☐ Yes ☐ No	I authorize the release of arthe person(s) listed above.	ny records regarding drug, ak	cohol, or mental health treatment to
Patient Signa	ture:	Date 9	Signed:





THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND RELEASED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

Who Will Follow This Notice:

This notice describes our practice's privacy practices and that of:

- Any physician or health care professional authorized to enter information into your medical chart.
- All areas of the practice
- · All employees, staff, and other office personnel
- All these individuals, sites and locations follow the terms of this notice. In addition, these individuals, sites and locations may share medical information with each other or with third party medical specialists for treatment, payment, or office operations purposes described in this notice

Our Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our medical 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 release medical information about you. We also describe your rights and certain obligations we have regarding the use and release of medical information.

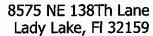
We are required by law to:

- 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 this notice that is currently in effect

How We May Use and Release Medical Information About You:

The following categories describe different ways that we use and disclose medical information. Not every use or release category will be listed. However, all of the ways we are permitted to use and release 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 release medical information about you to the practice's office personnel who are involved in taking care of you at the office or elsewhere. We also may release medical information about you to people outside our office who may be involved in your care after you leave the office, such as family members or others we use to provide services that are part of your care provided you have consented to such release. These entities include third party physicians, hospitals, nursing homes, pharmacies or clinical labs with whom the office consults or makes referrals.
- For Payment: We may use and release medical information about you so that the treatment and services you receive at the medical 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 medical procedures you received at the 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 Health Care Operations: We may use and release medical information about you for medical office operations. These uses and releases are necessary to run the medical 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 medical office patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also release information to physicians, nurses, and other office personnel for review and learning purposes.
- **Appointment Reminders:** We may use and release medical information to contact you as a reminder that you have an appointment for treatment or medical care at the office.
- **Treatment Alternatives:** We may use and release 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 release medical information to tell you about health-related benefits or services that may be of interest to you.
- Individuals Involved In Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care provided you have consented to such release. We may also give information to someone who helps pay for your care. In addition, we may release medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- 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 release 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 release, however, would only be to someone able to prevent the threat.

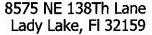
Special Situations:

- Health Oversight Activities: We may release 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 health care
 system, government programs and compliance with civil rights laws.
- Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may release medical information about you in response to a court or administrative order. We may also release 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 to tell you about the request or to obtain an order protecting the information requested.
- Coroners, Medical Examiners and Funeral Directors: We may also 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 of the office to
 funeral directors as necessary to carry out their duties.

Your Rights Regarding Medical Information About You:

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

• Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our office manager. If you request a copy of the information, there will be a fee for the costs of copying, mailing, or other office supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances.





- 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 medical office. To request an amendment, your request must be made
 in writing and submitted to the office manager. 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:
 - 1. Was not created by us, unless the person or entity that created the
 - 2. information is no longer available to make the amendment;
 - 3. Is not part of the medical information kept by or for the medical office;
 - 4. Is not part of the information which you would be permitted to inspect and copy; or
 - 5. 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 the releases we made of medical information about you.

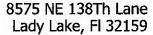
To request this list of disclosures, you must submit your request in writing to our medical records department. Your request must state a time period which may not be longer than six years and may not include dates before 4-13-03. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the cost 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 release about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we release 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 release information about a surgery 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. In your request, you must tell us

- (1) what information you want to limit;
- (2) whether you want to limit our use, release or both; and
- (3) to whom you want the limits to apply, for example, releases 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 office manager. 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, you
 may request a copy from our front office staff.





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 the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top left hand corner, the effective date. In addition, each time you register we will offer you a copy of the current notice in effect.

Complaints:

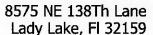
If you believe you privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our practice manager. All complaints must be submitted in writing.

You will not be penalized or retaliated against for filing a complaint.

Other Uses Of Medical Information:

Other uses and releases 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 release medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or release medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any release we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

If you have any questions about this notice, please contact the practice manager.





Notice of privacy practice acknowledgement form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment or healthcare operations as described in our Notice. You have the right to revoke this consent in writing, except we have already made releases in reliance on your prior consent.

Patient Signature:	
Patient Name:	
Date:	
Witness:	