Acclaimed Heart and Vascular Center

Arsalan Shahzad, MD FACC

Vintage Park Office
20207 Chasewood Park Dr
Ste 305,
Houston, TX 77070

Tomball Office
455 School St
Ste 11,
Tombal, TX 77375

www.Care4Heart.com
(281)290-0222

NAME: ____ DOB: _________________

Please List **ALL** of your current Medications (**Cardiac Meds first**)

Name of Medication	Strength	Times per day	Allergies
			( ) Latex & Reaction:
			( ) Iodine & Reaction:
			( ) Other:
			List all allergies to medications:

(Ad) Adopted **(M) Mother** **(F) Father** **(So)** Son **(D)** Daughter **(B)** Brother **(Si)** Sister **(PGF)** Paternal Grandfather **(PGM)** Paternal Grandmother **(MGF)** Maternal Grandfather **(MGM)** Maternal Grandmother **(Au)** Aunt **(U)** Uncle

Self (X)	Medical Condition	Family Member
	Coronary Artery Disease	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Heart Attack	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Cardiac Arrest	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Angioplasty or Sent of Heart Arteries	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Coronary Artery Bypass	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Peripheral Vascular Disease (PAD or PVD)	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Angioplasty or stent of Leg Arteries	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Carotid Stenosis (Blockage)	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Carotid Artery Surgery or Stent	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Abdominal Aortic Aneurysm	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Stroke	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Atrial Fibrillation or Atrial Flutter	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Diabetes	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	High cholesterol	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	High blood Pressure	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Pacemaker Placement	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Defibrillator Placement	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Congestive Heart Failure	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	COPD	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Blood Clots in Lungs (Pulmonary Embolism)	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Blood Clots of Leg Veins (DVT)	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Hypothyroidism	**( )Ad( )M( )F( )So( )Da( )Bro( )Sis( )PGF( )PGM( )MGF( )MGM( )Au( )Un**
	Any other significant Medical history	

Surgical History: ( )Stent ( )CABG ( )Cataract ( )C-Section ( )Broken bone repair ( )Hysterectomy ( )Gallbladder Removal ( )Appendicitis Removal

Hospitalization and Please specify When, Where, and the Reason:

____

Are you married?	( ) Yes ( ) No		
Do you currently smoke?	( ) Yes ( ) No	How many a day?	
Are you a former smoker?	( ) Yes ( ) No	How many a day?	Quitting year?
Do you drink alcohol?	( ) Yes ( ) No	How many a day?	
Do you use recreational drugs?	( ) Yes ( ) No		
Do you exercise?	( ) Yes ( ) No	What type of exercise	
Do you drink caffeine?	( ) Yes ( ) No	What type of Caffeine	

Occupation: ______________________________

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Patient Name: Last ______________________________**First** ________________________ **Middle Initial**_______

Address____ **State** __________ **Zip** _________________

Home _________________________ **Work** ______________________ **Cell** _______________________________

Social Security # _______-________-________ **Male**____ **Female**____ **Race**: ___________________________

Date of Birth_____/_____/______ **Marital Status:** Married______ Single_____ Widow______ Divorced______

Pt Email Address____@_______________________________________

Emergency Contact Name: ____________________**Relationship**_______________ **Phone #** _________________

Email Address ____@___________________________________

Who may we thank for referring you? ____

____

Primary Care & Referring Physician__________________________________**Phone**__________________________

Pharmacy: _____________________________________ **Phone/Location**____________________________________

EMPLOYER

Company____ Occupation_____________________

☐ Full-time ☐ Part-time Years Employed______________

Address: ____ Phone_______________________________

City ___________________________________ State _______________ Zip_________________

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for?

Yes **No** Your Initials: ___________

INSURANCE

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have:
Insurance Company or Health Care Plan Name___________________________________
ID/ Subscriber #____
Policy/Group #:____
Effective Date: ____
Name of Insured: __________________________________ DOB: __________________

COINSURANCE

Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have
Insurance Company or Health Care Plan Name_____________________________________
ID/ Subscriber #____
Policy/Group #:____
Effective Date: ____
Name of Insured: __________________________________ DOB: ____________________

I authorize AHVC to contact me in the following manner: (Please check all that apply)

Home Phone____ **Work** Phone____ **Cell** Phone ____ Text Message____ Email____

( ) You may leave messages on my answering machine or voice mail with **detailed message.**

( ) You may leave messages identifying the practice/physician and leaving a call back number only.

( ) You may leave messages with a family member (Please identify by name and relationship below).

____

Patient Agreement &Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws

Legal Assignment of Benefits And Designation Of Authorized Representative
In considering the amount of medical expenses to be incurred the insurance and/or employee of health care benefits coverage with the patient, and hereby assign and convey directly to AHVC, the healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to AHVC, to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

Signature____ Date____________________________

By signing below I acknowledge that I have received and understand the guidelines set forth by this office for the implementation of HIPPA. I have read and fully understand the HIPAA Notice of Privacy Practices, **Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws and Legal Assignment Of Benefits And Designation Of Authorized Representative.**

Signature ____ Date:_____________________

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please fax back to 281-290-0233

I authorize Acclaimed Heart and Vascular Center ("AHVC") to ( ) release **TO** ( ) receive **FROM**

________________________________	________________________________
Doctors name or Facility	Address
________________________________	________________________________
Phone #	Fax #

Information / Medical Records on:

________________________________	________________	________________
Patients Name	Date of Birth	SS#

Date(s) of Service: ( ) ALL ( ) Dates ________________________________

Information to be released:

( ) **ALL Cardiovascular and Medical Records**
( ) EKG REPORT ( ) LABS ( ) ECHO ( ) STRESS REPORT ( ) LAST NOTE
( ) Cardiovascular Study ( ) Other____

This information is being released for the following purpose (s):

( ) Medical / Continued Care ( ) Attorney / Litigation ( ) Insurance ( ) Disability Services
( ) Clearance ( ) Other____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire (365) days from the date of my signature, unless specified in writing here:_______. I understand that it may take up to 15 business days for the revocation to take effect
I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company of non-health care provider; the released information may no longer be protected by the federal and state privacy regulations.

TO THE PARTY RECEIVING THIS INFORMATION:

This information has been disclosed to you from records whose confidentiality may be protected by federal law If so, federal regulations (42 CFR Part 2, and/or other applicable regulations/statutes) prohibit you otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2,
And/or other applicable regulations/statutes)

____	__________________
Printed Name of Patient or Legally Authorized Representative	Date
____	______________________________
Signature of Patient or Legally Authorized Representative	Relationship to Patient