

## New Patient History

Date \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

What doctor referred you to our clinic? Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

Reason for Visit \_\_\_\_\_

Pharmacy Name, Location, and Phone Number \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

**Medications:** List any medications you are currently taking, including over the counter medications. Please list any additional medications on back of sheet.

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Allergies:** Are you allergic to any medications:  YES  NO Are you allergic to Iodine?  YES  NO  
If YES, please list medication and reaction. \_\_\_\_\_

### Social History:

Smoking Status:

- Current Every Day Smoker  Former Smoker/Quit when \_\_\_\_\_  Heavy Cigar/Pipe Smoker  
 Current Some Day Smoker  Never Smoker  Light Cigar/Pipe Smoker

If you are a smoker, how many packs per day do you smoke? \_\_\_\_\_

Type of Tobacco:

- Cigarettes  Chewing Tobacco  
 Cigars  Vapor/E-Cigarettes  Smokeless Tobacco/Other  
 Pipe  Snuff

Do you drink alcohol?  YES  NO If yes, how much?  0-1 drinks/day  1-2 drinks/day  over 3 drinks/day

Caffeine (coffee, tea, soda, energy drinks, etc.):  NONE  0-1 drinks/day  1-2 drinks/day  over 3 drinks/day

Do you use illicit drugs?  NEVER  YES TYPE/FREQUENCY \_\_\_\_\_

Marital Status:  SINGLE  MARRIED  DIVORCED  WIDOWED

Are you employed?  YES  NO Is your work:  SEDENTARY  NORMAL  LABOR INTENSIVE

Are you retired?  YES  NO

Do you exercise:  YES  NO If so, what type and how often? \_\_\_\_\_

**Family History:**

	Mother	Father	Brother/ Sister	Brother/ Sister	Brother/ Sister	Son/ Daughter	Son/ Daughter	Son/ Daughter
Age								
If Deceased, Age at Death								
Cause of Death								
<b>Check All That Apply</b>	Arrhythmia							
	Coronary Artery Disease							
	Heart Attack							
	Abdominal Aortic Aneurysm							
	Heart Failure							
	Hyperlipidemia							
	Hypertension							
	Sudden Cardiac Death							
	Stroke							
	Asthma							
	COPD							
	Diabetes							
	Cancer							

**Medical History:** Have you ever had any of the following illnesses?

	YES	NO		YES	NO
Rheumatic Fever	( )	( )	Stroke	( )	( )
Chest Discomfort	( )	( )	Hepatitis	( )	( )
Heart Attack	( )	( )	Stomach Ulcers	( )	( )
Heart Disease	( )	( )	Diabetes	( )	( )
High Blood Pressure	( )	( )	Emphysema/Asthma	( )	( )
Tuberculosis	( )	( )	Arthritis	( )	( )
Kidney Disease	( )	( )	AIDS	( )	( )
Thyroid Disease	( )	( )	Cancer	( )	( )
Elevated Cholesterol	( )	( )	Phlebitis	( )	( )
Carotid Disease/Blockage	( )	( )	Sleep Apnea	( )	( )
Peripheral Vascular Disease/Blockage	( )	( )	If you have sleep apnea, do you wear a CPAP?	( )	( )

**Previous Cardiac Testing:**

	YES	NO	Date	Place
Ultrasound of Heart	( )	( )	_____	_____
Stress Test (Treadmill)	( )	( )	_____	_____
Heart CT Scan (Calcium Score)	( )	( )	_____	_____
Ultrasound of Legs			_____	_____

**Surgical / Procedure History:**

Arteriogram (Cath)	( )	( )	_____	_____
Angioplasty (Balloon)	( )	( )	_____	_____
Stent in the Heart	( )	( )	_____	_____
Open Heart Bypass Surgery	( )	( )	_____	_____
Heart Valve Replacement	( )	( )	_____	_____
Pacemaker or Defibrillator	( )	( )	_____	_____

Other surgeries or procedures: Please list any other surgeries and the approximate date:

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**Peripheral Vascular Disease**

- Do you experience aching or cramping in your legs, thighs, or buttocks when walking or exercising?  YES  NO
- If yes, does the pain go away with rest?  YES  NO
- Do you limit exercise due to leg cramps and/or pain?  YES  NO
- Do you have numbness and tingling in your legs or feet?  YES  NO
- Do you have open sores or ulcers on your leg(s) or feet that will not heal?  YES  NO
- Do you suffer from varicose veins?  None  Some  Moderate  Severe
- Do you suffer from spider veins?  None  Some  Moderate  Severe
- Do you wear compression stockings?  None  Intermittent  Daily

**Review of Systems:**

Please check any of the symptoms you have experienced in the last 30 days. Any unchecked boxes will be assumed to be negative. Please check here if you are not experiencing any of the below symptoms:

**Constitutional**

- Fatigue
- Fever
- Insomnia
- Weight gain
- Weight loss

**Head/Neck**

- Headache
- Neck Pain

**Eyes**

- Blurred vision
- Decreased vision
- Glaucoma
- Cataracts

**Ear, Nose, Mouth, and Throat**

- Earache
- Nasal Congestion
- Sore throat
- Ringing in ears

**Cardiovascular**

- Chest pain
- Pain in legs with walking
- Decreased exercise tolerance
- Palpitation
- Awakened with breathing difficulty
- Difficulty breathing lying flat
- Swelling in your legs/feet

**Pulmonary**

- Cough
- Shortness of breath
- Snoring
- Sputum production
- Wheezing

**Gastrointestinal**

- Abdominal pain
- Constipation
- Diarrhea
- Heartburn
- Blood in stools
- Loss of appetite
- Nausea
- Vomiting

**Genitourinary**

- Pain on urination
- Urinary frequency
- Incontinence
- Frequent urination at night
- Urinary hesitancy

**Musculoskeletal**

- Back pain
- Foot pain
- Joint pain/stiffness
- Hip pain

**Neurologic**

- Confusion
- Lightheaded/Dizziness
- Loss of balance/coordination
- Slurred speech
- Passing out
- Weakness

**Psychiatric**

- Anxiety
- Depression

Form Revision #	Form Changes
OHHP-F579 (Rev. 1/18)	Changed Logo
OHHP-F579 (Rev.11/20)	Removed Logo

PLEASE PRINT

PATIENT INFORMATION

If this is work-related, stop and notify receptionist.

Form containing patient personal information: Date, Referring Physician & Phone Number, Family Physician & Phone Number, OHHP Physician & Phone Number, LEGAL NAME (Last, First, Middle, Sex), Preferred Name, Address, City, State, Zip, Country, Home Telephone, Age, Birthdate, Marital Status, SS#, Race, Ethnicity, Religion, Language, Interpreter needed, Employer, Employment Status, Business Phone & Ext., Cell Phone, Pager, E-Mail, Next of Kin (NOK), Emergency Contact (EMC).

SPOUSE/PARENT INFORMATION

Form containing spouse/parent information: Spouse/Parent, Spouse or parent information (if child under 18), Relation to Patient, Home Telephone, Cell Phone, Employment Status, Employer, SS#, Birthdate, Age, Work Phone & Ext., Address, City, State, Zip.

INSURANCE INFORMATION (Provide cards to copy)

Do you have Health Insurance Coverage? Yes or No (If yes, please complete the primary and secondary info below.)

Form containing insurance information: Primary Insurance (Insurance Type: Group, Individual, Cobra), Insured's Name on Card, I.D. #, Group #, Insured's Birthdate, Patient Relation to Insured, Insured's Sex, Insured's SS#, Secondary Insurance (Insurance Type: Group, Individual, Cobra), Insured's Name on Card, I.D. #, Group #, Insured's Birthdate, Patient Relation to Insured, Insured's Sex, Insured's SS#.

OTHER INFORMATION

I authorize the release of medical information required to process all claims on my behalf. I also authorize payment of insurance benefits from those claims be made payable to: OKLAHOMA HEART HOSPITAL PHYSICIANS. I understand I am financially responsible for any charges not covered by my insurance.

Table with 2 columns: Form Revision #, Form Changes. Rows include OHHP-F67 (Rev. 1/18) Changed Logo and OHHP-F67 (Rev. 11/20) Removed Logo.

PATIENT OR AUTHORIZED PERSON

DATE

## Release of Protected Health Information To Family Members and Persons Involved in Patient's Care

With your permission, OHHP (Oklahoma Heart Hospital Physicians) may release your protected health information to a family member or another person involved in your care or payment for your health care. For example, OHHP may tell a family member when your next medical appointment is scheduled, the results of a laboratory test or procedure or provide the person with a copy of a prescription. Pharmacies will also be notified or sent a list of your medications if required for continuance of care. By completing the top portion of this form, you are authorizing OHHP to release this information to these individuals. However, you are not authorizing OHHP to provide extensive information about your medical history or copies of information from your medical record. If you wish to have this information disclosed, you must complete a separate HIPAA authorization form. Please be aware that OHHP may use its professional judgment in determining the amount of information it may disclose to any person besides yourself, and in refusing to disclose your health information.

Please identify the person or persons who are involved in your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend or guardian. Please list below:

Name	Relationship	Phone Number (Optional)

### Authorization to Leave Voice and Email Messages

OHHP is required to have your permission to leave voice messages or send email messages regarding your Protected Health Information (test results, instruction, etc.) Please check the appropriate boxes:

- Yes, OHHP may leave a message on my answering machine/voice mail regarding my Protected Health Information.
- No, OHHP may not leave a message on my answering machine/voice mail regarding my Protected Health Information.
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- Yes, OHHP may email me a message regarding my Protected Health Information.
- No, OHHP may not email me a message regarding my Protected Health Information.

***I understand that if I change my mind about any of the information in this form, I must contact OHHP to revoke this form in its entirety or to complete a new form.***

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Verbally Taken by (OHHP Employee)

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Witness (OHHP Employee)

Form Revision #	Form Changes
OHHP-F268 (Rev. 1/18)	Changed Logo
OHHP-F268 (Rev. 11/20)	Removed Logo; Added phone #

Patient Name: \_\_\_\_\_

Admission Date: \_\_\_\_\_ DOB: \_\_\_\_\_

## MSP Questionnaire

### PART I

1. Are you currently enrolled in a SNF or Hospice facility?

Yes. What is the name, address and phone number of the facility?

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

No.

2. Are you receiving Black Lung (BL) Benefits?

Yes. Date benefits began: \_\_\_\_/\_\_\_\_/\_\_\_\_ MM/DD/YY

(Staff only: BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.)

No.

3. Are the services to be paid by a government research program?

Yes. (Staff only: GOVERNMENT PROGRAMS WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.)

No.

4. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

Yes. (Staff only: DVA IS PRIMARY FOR THESE SERVICES.)

No.

5. Was the illness/injury due to a work-related accident/condition?

Yes. Date of injury/illness: \_\_\_\_/\_\_\_\_/\_\_\_\_ MM/DD/YY

**Patient: IF YES, GO TO PART III AND CONTINUE.**

(Staff only: WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS.)

No.

### PART II

1. Was the illness/injury related to a non-work related accident?

Yes. Date of injury/illness: \_\_\_\_/\_\_\_\_/\_\_\_\_ MM/DD/YY

No. **Patient: IF NO, GO TO PART III.**

2. Is no-fault insurance available?

Yes. **Patient: IF YES, GO TO PART III AND CONTINUE.**

(Staff only: WE DO NOT FILE NO-FAULT INSURANCE. PATIENT WILL BE SELF PAY.)

No.

3. Is liability insurance available?

Yes. (Staff only: WE DO NOT FILE LIABILITY INSURANCE. PATIENT WILL BE SELF PAY.)

No.

Patient Name: \_\_\_\_\_

**PART III**

1. Are you entitled to Medicare based on:

- Age            **Patient: COMPLETE PART IV ONLY.**  
 Disability      **Patient: COMPLETE PART V ONLY.**  
 End-Stage Renal Disease (ESRD)      **Patient: COMPLETE PART VI ONLY.**

**PART IV - Age**

1. Are you currently employed?

- Yes.    No.    No, never employed.    No, retired.   Date of retirement: \_\_\_\_/\_\_\_\_/\_\_\_\_ MM/DD/YY

2. Is your spouse currently employed?

- Yes.    No.    No, never employed.    No, retired.   Date of retirement: \_\_\_\_/\_\_\_\_/\_\_\_\_ MM/DD/YY

**Patient: IF NO TO BOTH QUESTIONS 1 AND 2, STOP. DO NOT PROCEED. (Staff: MEDICARE IS PRIMARY.)**  
**Patient: IF YES TO QUESTIONS 1 AND 2, CONTINUE.**

3. Do you have a Group Health Plan (GHP) coverage based on your own or your spouse's current/former employment?

- Yes, both.    Yes, self.    Yes, spouse.  
 No.

4. Are you covered under the Group Health Plan (GHP) of a family member other than your spouse?

- Yes.  
 No.   **(Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS 1 OR 2.)**

5. Does the employer that sponsors the patient's Group Health Plan (GHP) employ 20 or more employees?

- Yes.   **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**  
 No.   **(Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS 1 OR 2.)**

6. Does the employer that sponsors your Group Health Plan (GHP) employ 100 or more employees?

- Yes.   **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**  
 No.   **(Staff: MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS 1 OR 2.)**

Patient Name: \_\_\_\_\_

**PART V - Disability**

1. Are you currently employed?  
 Yes.  No.  No, never employed.  No, retired. Date of retirement: \_\_\_/\_\_\_/\_\_\_ MM/DD/YY

2. Do you have a spouse who is currently employed?  
 Yes.  No.  No, never employed.  No, retired. Date of retirement: \_\_\_/\_\_\_/\_\_\_ MM/DD/YY

**Patient: IF NO TO BOTH QUESTIONS 1 AND 2, STOP. DO NOT PROCEED. (Staff: MEDICARE IS PRIMARY.)  
Patient: IF YES TO QUESTIONS 1 AND 2, CONTINUE.**

3. Do you have a Group Health Plan (GHP) coverage based on your own or your spouse's current/former employment?  
 Yes, both.  Yes, self.  Yes, spouse.  
 No.

4. Are you covered under the Group Health Plan (GHP) of a family member other than your spouse?  
 Yes.  
 No. (Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS IN PART I OR II.)

5. Does the employer that sponsors the patient's Group Health Plan (GHP) employ 20 or more employees?  
 Yes. (Staff: GROUP HEALTH PLAN IS PRIMARY.)  
 No. (Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS IN PART I OR II.)

6. Does the employer that sponsors your Group Health Plan (GHP) employ 100 or more employees?  
 Yes. (Staff: GROUP HEALTH PLAN IS PRIMARY.)  
 No. (Staff: MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.)

**PART VI – End-Stage Renal Disease (ESRD)**

1. Do you have a Group Health Plan (GHP) coverage based on your own or your spouse's current/former employment?  
 Yes.  
 No.

2. Are you covered under the Group Health Plan (GHP) of a family member other than your spouse?  
 Yes.  
 No. (Staff: MEDICARE IS PRIMARY.)



Patient Name: \_\_\_\_\_

**PART VI – End-Stage Renal Disease (ESRD) Continued**

3. Does the employer that sponsors the patient’s Group Health Plan (GHP) employ 20 or more employees?
- Yes. (Staff: **GROUP HEALTH PLAN IS PRIMARY.**)  
 No. (Staff: **MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS IN PART I OR II.**)
4. Does the employer that sponsors your Group Health Plan (GHP) employ 100 or more employees?
- Yes. (Staff: **GROUP HEALTH PLAN IS PRIMARY.**)  
 No. (Staff: **MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**)
5. Have you ever received a kidney transplant?
- Yes. Date of transplant: \_\_\_\_/\_\_\_\_/\_\_\_\_ MM/DD/YY  
 No.
6. Have you received maintenance dialysis treatments?
- Yes. Date of maintenance: \_\_\_\_/\_\_\_\_/\_\_\_\_ MM/DD/YY  
 No.
7. Are you within the 30-month coordination period?
- Yes. Date coordination period began: \_\_\_\_/\_\_\_\_/\_\_\_\_ MM/DD/YY  
 No. **Patient: STOP. DO NOT PROCEED.** (Staff: **MEDICARE IS PRIMARY.**)
8. Are you entitled to Medicare on the basis of either (ESRD and AGE) or (ESRD and DISABILITY)?
- Yes.  
 No. (Staff: **GHP IS PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**)
9. Was the initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?
- Yes. (Staff: **GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**)  
 No. (Staff: **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**)
10. Does the working age or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?
- Yes. (Staff: **GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**)  
 No. (Staff: **MEDICARE CONTINUES TO PAY PRIMARY.**)

Date & Version #	Form Changes
OHHP-F496 (Rev. 1/18)	Changed Logo
OHHP-F496 (Rev. 11/20)	Removed Logo