



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
- Heavy Cigar/Pipe Smoker
- Current Some Day Smoker
- Never Smoker
- Light Cigar/Pipe Smoker

Type of Tobacco:

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

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								
Check All That Apply	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:

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 (N. 11/14)	Original

PLEASE PRINT



OKLAHOMA HEART HOSPITAL

Outpatient Clinic

OFFICE USE ONLY: INITIALS

ACCOUNT #

Initials and Account # input fields

PATIENT INFORMATION

Patient information form including Date, Referring Physician, Home Telephone, Race, Ethnicity, Religion, Language, and Spouse/Parent information.

SPOUSE/PARENT INFORMATION

Spouse/Parent information form including Spouse/Parent name, Address, City, State, Zip, and Work Phone & Ext.

WORKERS COMPENSATION INFORMATION

Workers Compensation information form including Employer Name, Date of Injury, Description of Injury, Work Comp Carrier Name, and Adjuster information.

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.

PATIENT OR AUTHORIZED PERSON

DATE

Table with 2 columns: Form Revision #, Form Changes. Rows include OHHP-F279PB (Rev. 9/11) Original and OHHP-F279PB (Rev. 2/13) Revision table added.



OKLAHOMA HEART HOSPITAL



OKLAHOMA HEART HOSPITAL PHYSICIANS

Patient Name: _____
Admission Date: _____
MRN: _____

CONDITIONS OF ADMISSION

Medical and Surgical Consent: The patient, or his or her representative, hereby acknowledges the patient’s need for hospitalization or treatment because he or she suffers from a condition requiring diagnosis and medical and/or surgical treatment. The undersigned requests and voluntarily consents to the patient’s receipt of the usual Hospital services, as well as the diagnostic laboratory (such as testing of the blood and other bodily fluids), x-ray procedures, medical and/or surgical treatment, including administration of anesthesia judged to be necessary by the patient’s attending physician, his assistants or other physicians designated by him. The Hospital is authorized to retain, preserve and use for scientific or teaching purposes, or dispose of at its convenience any specimens or tissue removed from the patient’s body during hospitalization or treatment.

Assignment of Insurance Benefits: I hereby authorize payments from all insurance companies to be made directly to **OKLAHOMA HEART HOSPITAL** and/or **Oklahoma Heart Hospital Physicians** for benefits otherwise payable to me. I understand that I am financially responsible to the hospital for charges not covered by this assignment. I certify that the above information in support of this claim is true and correct.

Payment Responsibility: The undersigned understands that the patient, or another person who specifically agrees to guarantee payment for the patient, is responsible for the payment of all charges of the Hospital or Physician relating to services rendered by the Hospital or Physician to the patient that exceed any third party coverage, including applicable coinsurance payments and deductibles and all amounts for which payment has been denied by any third party. There are other services that will be billed separately from the hospital bill including services performed by other physician specialists who perform services for your care and treatment while a patient at Oklahoma Heart Hospital. Amounts due from the patient to the Hospital prior to execution of this Agreement may, at the sole discretion of the Hospital, be consolidated with, and made a part of, the amount due hereunder. The patient shall pay all costs of collection in connection with the enforcement of this commitment, including reasonable attorney’s fees and court costs incurred by the Hospital. You authorize personal contact from us or our third party collector, via telephone or cell phone numbers provided to us, including line voice, text, auto dialed or prerecorded message.

Other Uses of PHI: I understand that in-hospital staff committees may utilize data relating to my condition in the course of studies for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality. I understand that should the recipients use or publish such information or material that my identity shall be confidential and shall not be revealed under any circumstances.

Provider Based Billing: When seeing an OHH healthcare provider for any type of outpatient services, you will see a change in the way you are billed. Under “Provider Based” status, OHH is required to bill provider services in two parts. When your medical services are completed, OHHP will submit a claim for the professional fee and OHH will submit a claim for the facility fee. You will receive two statements/bills for your services – one from Oklahoma Heart Hospital and one from Oklahoma Heart Hospital Physicians. N/A

(Initial) I acknowledge receipt of the Provider Based Medicare Outpatient Coinsurance Notice; actual liability will depend on services furnished. N/A

Notification of HIV Testing: The undersigned has been notified of the testing of the patient’s blood for human immunodeficiency virus (also known as AIDS) if determined by the patient’s attending physician. This is necessary (i) for determining the appropriate treatment and/or treatment procedures for the patient or (ii) for the protection of the attending physician and/or any employee or agent of the Hospital or the attending physician exposed to the bodily fluids of the patient in a manner which could transmit such disease. (Initial)

Facility Directory: Unless I object, I understand that my name, location, general condition, and religious affiliations may be released to the clergy or to others who ask for me by name. Agree Object (If I object, I understand I cannot receive phone calls, deliveries, etc.) (Initial)

Acknowledgment of Notice of Privacy Practices: I have received/reviewed the “Notice of Privacy Practices” from Oklahoma Heart Hospital. If I have any questions, I know to contact the Privacy Officer whose information is provided to me in the “Notice of Privacy Practices”. I understand that if I request a copy of this form one will be provided to me by the Registration staff. (Initial)

Disclosure of Physician Interest: The Oklahoma Heart Hospital has financial relationships with a number of Oklahoma physicians, some of whom have an ownership interest in the Hospital, and some of whom are paid by the Hospital for services they provide. If the physician who recommended the Hospital to you has a financial interest, and if his or her financial relationship with the Hospital concerns you, you may be treated at an alternative facility, if there is one available. If you would like to discuss your options for treatment at other facilities, or if you have any questions about this disclosure, please ask the person providing you with this form for assistance. A list of physician owners has been provided to me. (Initial)

THE UNDERSIGNED CERTIFIES THAT HE HAS READ THE FOREGOING AND IS THE PATIENT, OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT’S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

Date

Patient, Patient’s Agent or Representative

Witness

Agent or Representative’s Relationship to patient

Date & Version #	Change Summary
11/24/2015 Ver 4	Multiple Changes
02/24/2017 Ver 5	Multiple Changes



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

With your permission, OHHP 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

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.
-
- 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-F268PB (Rev. 2/13)	Added revision table
OHHP-F268PB (Rev. 3/13)	Added verbal/witness