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								
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 (Rev. 1/18)	Changed Logo
OHHP-F579 (Rev.11/20)	Removed Logo

PLEASE PRINT

OFFICE USE ONLY: INITIALS | **ACCOUNT #**

PATIENT INFORMATION

Date	Referring Physician	Referring Physician Phone

Last	First	Middle	Sex
			❑ M ❑ F

Address	City	State	Zip

Home Telephone	Age	Birthdate	Marital Status	SS#
( )		/ /	S M W D DEP	– –

Race:	Ethnicity:	Religion:	Language:	Interpreter needed?
❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Native American ❑ Pacific Islander ❑ Other	❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino		❑ English ❑ Spanish ❑ Other	❑ Yes ❑ No

Employer	Address	City	State	Zip

Work Phone & Ext.	Cell Phone	Pager	E-Mail	May we contact you through email?
( )				Yes No

Next of Kin (NOK)	Relation	Home Phone	Work Phone & Ext.
		( )	( )

Emergency Contact (EMC)	Relation	Home Phone	Work Phone & Ext.
		( )	( )

SPOUSE/PARENT INFORMATION

Spouse/Parent	Relation to Patient	Home Telephone
		( )

Address	City	State	Zip

Employer	SS#	Birthdate	Age	Work Phone & Ext.
	– –	/ /		( )

WORKERS COMPENSATION INFORMATION

Employer Name	Employer Phone #
	( )

Date of Injury

Description of Injury

Work Comp Carrier Name	Claim #

Address	Phone #
	( )

Name of Adjuster	Phone #
	( )

Attorney Name

Address	Phone #
	( )

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 _____

Form Revision #	Form Changes
OHHP-F279 (Rev. 6/17)	NOK & ER Contact
OHHP-F279 (Rev. 11/20)	Removed Logo

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.

☐ 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. P**atient: 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