CARDIOVASCULAR SURGERY CLINIC, PLLC
Phone 901-747-3066 Fax 901-747-2966

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of medical records to: (PLEASE CIRCLE ONE)

Dr.Anton DiasPerera, Dr. H. Edward Garrett,

The authorization will expire on: _____
Date or Event may not exceed one year

Purpose of release (i.e. evaluate for surgery, evaluate condition, second opinion, attorney, etc.)

_____

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____

Signature of Patient or Authorized Representative Date Signed

_____

Relationship to Patient

CARDIOVASCULAR SURGERY CLINIC – PATIENT MEDICATION LIST

NAME_____ **DATE OF BIRTH**_____ **TODAY'S DATE**_____

PLEASE LIST ALL OF YOUR MEDICATIONS – PRESCRIPTION, OVER THE COUNTER, HERBAL SUPPLEMENTS AND VITAMINS, INHALERS, PATCHES			
MEDICATION NAME	**What is the dose or strength?**	**How often do you take it?**	**When did you start taking this medication?**

SOME MEDICATIONS CAN CAUSE SERIOUS BLEEDING DURING SURGERY, PLEASE INCLUDE EVERYTING.

DO YOU HAVE ANY ALLERGIES? NO YES

List what you are allergic to and problem that it causes. (Example: medications, contrast dye, foods, latex, tape)

CARDIOVASCULAR SURGERY CLINIC – HEALTH HISTORY 2

NAME_____ **DATE OF BIRTH**_____ **TODAY'S DATE**_____

CONSTITUTIONAL	Present	Past	No
Fatigue	☐	☐	☐
Fever or chills	☐	☐	☐
Night sweats	☐	☐	☐
Weight loss	☐	☐	☐
Loss of appetite	☐	☐	☐

EYE	Present	Past	No
Glasses/ Contacts	☐	☐	☐
Vision loss	☐	☐	☐
Blurry vision	☐	☐	☐
Glaucoma	☐	☐	☐
Cataracts	☐	☐	☐
Blind spot in vision	☐	☐	☐

EARS/NOSE/THROAT	Present	Past	No
Dentures	☐	☐	☐
Difficulty swallowing	☐	☐	☐
Hoarseness	☐	☐	☐
Sinus problems	☐	☐	☐
Nose bleeds	☐	☐	☐
Hard of hearing	☐	☐	☐

CARDIAC	Present	Past	No
High blood pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Chest pain	☐	☐	☐
Irregular heart beat	☐	☐	☐
Palpitations	☐	☐	☐
Atrial fibrillation	☐	☐	☐
Coronary artery disease	☐	☐	☐
Congestive heart failure	☐	☐	☐
Heart attack	☐	☐	☐
Short of breath at rest	☐	☐	☐
Short of breath w/activity	☐	☐	☐
Short of breath at night	☐	☐	☐
Short of breath lying flat	☐	☐	☐
Sleeping with #_____ pillows/wedge			
Heart valve problem	☐	☐	☐
Aneurysm	☐	☐	☐
Pacemaker or AICD	☐	☐	☐
Peripheral vascular disease	☐	☐	☐
Leg Swelling/Edema	☐	☐	☐
Varicose veins	☐	☐	☐

RESPIRATORY	Present	Past	No
Short of breath	☐	☐	☐
Dry cough	☐	☐	☐
Productive cough	☐	☐	☐
Blood in sputum	☐	☐	☐
Asthma	☐	☐	☐
COPD/ Emphysema	☐	☐	☐
Tuberculosis	☐	☐	☐
Sleep apnea/CPAP	☐	☐	☐
Use OXYGEN at home	☐	☐	☐

GASTROINTESTINAL	Present	Past	No
Heartburn/ GERD	☐	☐	☐
Nausea	☐	☐	☐
Vomiting	☐	☐	☐
Abdominal pain	☐	☐	☐
Pain after eating	☐	☐	☐
Feel full w/very little food	☐	☐	☐
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Hemorrhoids	☐	☐	☐
Blood in stool	☐	☐	☐
Liver cirrhosis	☐	☐	☐
Hepatitis A B C	☐	☐	☐

IMMUNOLOGY	Present	Past	No
HIV/AIDS	☐	☐	☐
Steroid use	☐	☐	☐
Frequent infection	☐	☐	☐

CANCER	Present	Past	No
	☐	☐	☐

Type of cancer_____

_____

MUSCULOSKELETAL	Present	Past	No
Muscle weakness	☐	☐	☐
Back pain	☐	☐	☐
Arthritis	☐	☐	☐
Joint pain	☐	☐	☐
Gout	☐	☐	☐
Leg pain with walking	☐	☐	☐
Leg pain at rest	☐	☐	☐
Leg cramps at night	☐	☐	☐
Leg weakness	☐	☐	☐
Cold feet or toes	☐	☐	☐
Arm pain	☐	☐	☐
Arm weakness	☐	☐	☐
Cold arm or hand	☐	☐	☐

ENDOCRINE	Present	Past	No
Thyroid disease	☐	☐	☐
Diabetes	☐	☐	☐

HEMATOLOGY	Present	Past	No
Bruise/bleed easy	☐	☐	☐
Anemia	☐	☐	☐
DVT/blood clots	☐	☐	☐
Frequent nosebleeds	☐	☐	☐

NEUROLOGICAL	Present	Past	No
Stroke	☐	☐	☐
TIA/"mini stroke"	☐	☐	☐
Passing out episodes	☐	☐	☐
Fainting	☐	☐	☐
Seizures	☐	☐	☐
Tremors	☐	☐	☐
Headache	☐	☐	☐
Dizziness	☐	☐	☐
Difficulty speaking	☐	☐	☐
Paralysis _____	☐	☐	☐
Numbness in fingers hands	☐	☐	☐
Numbness in feet or legs	☐	☐	☐
Falls	☐	☐	☐
Unsteady when walking	☐	☐	☐

SKIN	Present	Past	No
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐

Other _____

GENITOURINARY	Present	Past	No
Urinary incontinence	☐	☐	☐
Difficulty urinating	☐	☐	☐
Frequent urination	☐	☐	☐
Painful urination	☐	☐	☐
Blood in urine	☐	☐	☐
Frequent urinary infection	☐	☐	☐
Kidney stones	☐	☐	☐
Kidney problems	☐	☐	☐
Hemodialysis	☐	☐	☐
Where is your graft/shunt_____			
Peritoneal dialysis	☐	☐	☐
Prostate trouble	☐	☐	☐

MENTAL HEALTH	Present	Past	No
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Memory loss	☐	☐	☐
Alzheimer's	☐	☐	☐
Dementia	☐	☐	☐

Other mental illness_____

Anything else that you would like to add:_____

CARDIOVASCULAR SURGERY CLINIC – HEALTH HISTORY 1

NAME_____ **DATE OF BIRTH**_____ **TODAY'S DATE**_____

HEIGHT____feet____inches

WEIGHT_____pounds

Reason for seeing the doctor today_____

Name of the physician or person that referred you today_____

Name of your primary care physician_____

Names of other physicians that treat you_____

Have you EVER had any surgery? NO YES

DATE	TYPE OF SURGERY	DOCTOR or HOSPITAL WHERE PERFORMED

Have you ever smoked cigarettes? NO YES Year that you started smoking_____ Packs per day_____

Do you still smoke? NO YES Year that you stopped smoking_____

Do you use any other form of tobacco? NO YES (circle all that apply) CIGAR PIPE CHEWING TOBACCO SNUFF

Do you drink alcohol? NO YES How much/how often/what type?_____
(ex: 8 beers daily, socially only, heavy weekend drinking, etc.)

Have you ever used "street drugs"? NONE PAST PRESENT MARIJUANA COCAINE METH Other_____

Do any of your immediate family members (Mother, Father, Brother, Sister) have any of the following?

Heart disease Bypass surgery Stroke Aneurysm Diabetes Cancer (circle all that apply)

Have you ever received a blood transfusion? NO YES

Did you have a reaction? NO YES Describe your reaction_____

Will you accept a blood transfusion if needed during surgery or a hospitalization? NO YES

CARDIOVASCULAR SURGERY CLINIC, PLLC

PATIENT INFORMATION				
Patient's LEGAL name		Date of birth	Marital status (circle one) M S D W Sep	
Social Security Number	Sex: (circle one) M F	Spouse's name	Spouse's date of birth	
Street address		City	State	Zip code
Home phone	Other phone	**Email address**		
May we leave a message? Y N	May we leave a message? Y N	May we send you emails regarding your care? Y N		
Employer ☐ Retired ☐ Disabled ☐ Not working		Occupation	Employer phone	
Referred by: (DOCTOR or friend or self referred)		**Primary Care Doctor:**		
(1) Emergency contact (someone NOT living with you)		Emergency contact phone number		
Please list family and/or friends that we may discuss your private health information:				
Pharmacy Name		Pharmacy phone number		
Race: ☐ Caucasian ☐ African-American ☐ American-Indian ☐ Asian ☐ Pacific Islander ☐ Other_____ ☐ Decline to answer ☐ Unavailable at this time		Ethnicity: ☐ Decline to answer ☐ Hispanic ☐ Non-Hispanic ☐ Other		
Preferred language: ☐ English ☐ Spanish ☐ Other:_____				

INSURANCE INFORMATION-*WE WILL NEED A COPY OF YOUR INSURANCE CARDS*	
Primary insurance	Policy #
Subscriber's name	Subscriber's date of birth:
Secondary Insurance	Policy #

NOTICE OF PRIVACY PRACTICES
I have been offered a copy of the Notice of Privacy
X

PERMISSION TO EVALUATE AND TREAT
I give Cardiovascular Surgery Clinic, PLLC to evaluate and treat me.
X

AUTHORIZATION AND FINANCIAL RESPONSIBILITY
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I understand that I will be responsible for any collection fees, attorney's fees and other collection costs. I also authorize Cardiovascular Surgery Clinic, PLLC or insurance company to release any information required to process my claims.
X