Heart and Vascular Wellness Center
Love Your Heart

Patient Information

Please print. All Information is Confidential

Patient Name:______________________________ ☐ Male ☐ Female DOB:______________

Home #: _________________ Cell #: _________________ Social Security #______________

Address:____
Address City State Zip

E-mail: ___________________________ Race ____________ Ethnicity_______________

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Spouse/Partner Name: _______________________________ Phone #:__________________

May we contact your spouse/partner if we cannot contact you: ☐ Yes ☐ No

PHARMACY: _______________ **ADDRESS:** _____________________**PHONE #:** ___________

PREFERRED LAB: __________________ **PACEMAKER DEVICE NAME:**____________________

HOW DID YOU HEAR ABOUT US? ____

Employer:_________________________________ Job Title:_________________________

Person to Contact in case of an emergency (not residing with you):

____
Name Relationship Phone #

Primary Physician: ___________________________ Phone #: _________________________

Referring Physician: __________________________ Phone #: ________________________

Insurance Information

Insurance Holder Name:________________________ Relationship to patient:________________

Date of Birth:__________________ SSN: ___________________

Insurance Company:_______________________________ ID#:_______________________

Do you have a second insurance? Yes No

Insurance Holder Name:________________________ Relationship to patient:________________

Date of Birth: __________________ SSN: ___________________

Insurance company: ______________________________ ID #: ________________________

CONSENT FOR TREATMENT

I hereby authorize and direct the physicians of Heart and Vascular Wellness Center to examine and treat me as is needed in their judgement. I acknowledge that the examination may include physical contact by the physician and/or his assistants. At times Dr. Oshodi participates in Resident / Observation programs. I agree with the Observer / Resident in the exam room.

__________________________________ ______________________
Patient signature **Date**

Name:__________________________ DOB:____________ Date:____________

Cardiovascular History/Procedures

Please indicate if you have had any of the following events or procedures

Event/Procedure	Dates	Hospital/Facility
Heart Attack ☐ Yes ☐No	________________	______________________
Heart Cath/Coronary Angiogram/Stents ☐ Yes ☐No	________________	______________________
Echocardiogram ☐ Yes ☐No	________________	______________________
Stress Test ☐ Yes ☐No	________________	______________________
Electrical Cardioversion ☐ Yes ☐No	________________	______________________
Electrophysiology Study/Ablation of abnormal heart rhythm ☐ Yes ☐No	________________	______________________
Angiogram/Angioplasty of the extremities ☐ Yes ☐No	________________	______________________
Venous Ablation/Vein Stripping ☐ Yes ☐No	________________	______________________
Cardiac Surgery/CABG/Bypass ☐ Yes ☐No	________________	______________________
Valve Surgery/Valve Replacement ☐ Yes ☐No	________________	______________________
Pacemaker/Defibrillator ☐ Yes ☐No	________________	______________________
Holter/Heart Monitor ☐ Yes ☐No	________________	______________________
Recorder/Implantation Heart Monitor ☐ Yes ☐No	________________	______________________

Name:____________________________________ DOB:__________________ Date:_______________

Present Medical History

General
☐ Anemia
☐ Change in appetite
☐ Chills
☐ Fatigue
☐ Night sweats
☐ Weight loss
☐ Weight gain

ENT
☐ Trouble seeing
☐ Teeth/Gum problems
☐ Decreased hearing

Endocrine
☐ Cold/Hot intolerance
☐ Diabetes
☐ Frequent urination
☐ Thyroid problems
☐ Weakness
☐ Weight loss

Respiratory
☐ Coughing up blood
☐ Stop breathing while sleeping
☐ Cough
☐ Shortness of breath w/ rest
☐ Shortness of breath w/ exertion
☐ Wheezing

Breast
☐ Breast lump
☐ Breast pain
☐ Chest muscle pain

Cardiovascular
☐ Chest /Arm pain or pressure
☐ Racing / Irregular heartbeat
☐ Fainting / Near fainting
☐ Discomfort in calf w/ walking
☐ Varicose veins
☐ Leg swelling
☐ Dyspnea on exertion
☐ Palpitations
☐ Shortness of breath
☐ Swelling of hands / feet
☐ High blood pressure

Gastrointestinal
☐ Abdominal pain
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Nausea
☐ Rectal bleeding
☐ Vomiting

Genitourinary
☐ Blood in urine
☐ Difficulty urination
☐ Frequency urination
☐ Painful urination

Musculoskeletal
☐ Back problems
☐ History of Gout
☐ Joint stiffness
☐ Muscle aches
☐ Painful joints

Peripheral Vascular
☐ Absent pulses in hands
☐ Absent pulses in feet
☐ Blood clots in legs
☐ Cold extremities
☐ Decreased sensation in extremities

Skin
☐ New growth / change in a mole
☐ Itching
☐ Rash
☐ Skin oozing

Neurologic
☐ Numbness on one side
☐ Numbness / burning in feet
☐ Dizziness
☐ Headaches
☐ Memory loss
☐ Stroke
☐ Seizures

Psychiatric
☐ Anxiety
☐ Depressed mood
☐ Substance abuse
☐ Suicidal thoughts

Name:________________________________ DOB:________________ Date:_____________

Female patients

Last Menstrual Period: _____________ Number of pregnancy: _____________

Deliveries: __________ Miscarriages: __________ Menopause (age): ___________

☐ N/A ☐ Currently pregnant ☐ Planning pregnancy

Previous Surgeries / Procedure / Hospitalizations

If so please list surgeries / procedures done and approximate dates done: ☐ None

1) ____ date: _________________________
2) ____ date: _________________________
3) ____ date: _________________________
4) ____ date: _________________________

Have you had any complications from any surgeries or procedures? Y / N (If so please explain)

____

____

Medication

Please list all medications and strengths that are being taken at this time ☐ None

1) Name:_______________________________________ Strength:_________________ How often:_________________
2) Name:_______________________________________ Strength:_________________ How often:_________________
3) Name:_______________________________________ Strength:_________________ How often:_________________
4) Name:_______________________________________ Strength:_________________ How often:_________________
5) Name:_______________________________________ Strength:_________________ How often:_________________
6) Name:_______________________________________ Strength:_________________ How often:_________________
7) Name:_______________________________________ Strength:_________________ How often:_________________
8) Name:_______________________________________ Strength:_________________ How often:_________________
9) Name:_______________________________________ Strength:_________________ How often:_________________
10) Name:_______________________________________ Strength:_________________ How often:_________________

Name:__________________________________ DOB:_________________ Date:______________

Allergies

Please list all allergies and reactions ☐ None

	Allergy:	Reaction:
1)	______________________	______________________
2)	______________________	______________________
3)	______________________	______________________
4)	______________________	______________________
5)	______________________	______________________
6)	______________________	______________________

Past Medical History

Check all that apply

☐ Hypertension
☐ High Cholesterol
☐ Heart Attack
☐ Cardiac Arrest
☐ Heart Failure
☐ Atrial Fibrillation
☐ Rheumatic Fever
☐ Aneurysm of Aorta
☐ Blood Clots
☐ Blood Clot in Lungs
☐ Stroke
☐ Ulcer in Stomach
☐ Crohn's Disease
☐ Diabetic Eye Problem
☐ Blood Transfusion
☐ Asthma
☐ Convulsions/Seizure
☐ Autoimmune Disorder
☐ HIV infection

☐ Radiation Therapy
☐ Chemotherapy
☐ Gallbladder Disease
☐ Gallbladder Stones
☐ Pancreatitis
☐ Hepatitis/Liver Disease
☐ Thyroid Disease
☐ Kidney Disease
☐ Kidney Stones
☐ Osteoporosis
☐ Gout
☐ Cancer:
☐ Other serious illness:
____
____

Name:______________________ DOB:______________ Date:______________

Social History

☐ Tobacco Use: ☐Never
☐Current everyday
☐Current some days If so, how often: ______________________
☐Socially If so, how often: ______________________
☐Quit If so, when: __________________________

☐ Alcohol Use: ☐Never
☐Current everyday
☐Current some days If so, how often: ______________________
☐Socially If so, how often: ______________________
☐Quit If so, when: __________________________

☐ Drug Use: If so, what type and how frequent:____

Do you live: ☐ Alone ☐Spouse ☐Children ☐Parent(s) ☐Other____________________

Family Medical History

Relative	**Alive or Deceased**	**Age (if deceased, at what age)**	**Medical Conditions**
Mother			
Father			
Maternal Grandparents			
Paternal Grandparents			
Siblings			
Children			

Name:________________________________ DOB:________________ Date:_____________

Acknowledgement of Receipt of
“Notice of Privacy Practices”

*I ____acknowledge that I have received a copy of Heart and Vascular Wellness Center’s **Notice of Privacy Practices**. This notice describes how Heart and Vascular Wellness Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights regarding my protected health information.*

I fully understand and accept the terms of this consent.

______________________________________ __________________________
Signature of Patient or Representative Date

____
Relationship to Patient

HIPAA: Personal relations not physician.
I choose to allow the following individuals to have access to my medical records and any information regarding my condition and treatment.

________________________________ Name	________________________________ Name
________________________________ Relationship to patient	________________________________ Relationship to patient
________________________________ Contact #	________________________________ Contact #

____ ______________
Signature of Patient Dat

Name:______________________________ DOB:_______________ Date:_____________

Authorization for Release of Protected Health Information

Patient Name: ______________________________________ Date of Birth: _____________

Phone Number: ____________________________________

I hereby Authorize:

Heart and Vascular Wellness Center
40700 California Oaks Rs. Suite 208
Murrieta, CA 92562
P: (951) 696-0004 F: 951-696-0007

☐ To obtain my information from or ☐ Release my information to

Facility Name: ____

Fax: ________________________________

STATUS: ☐ **STAT** ☐ 2nd ATTEMPT ☐ Patient Appointment: _______________

This authorization is for full disclosure of all medical records. Including:

Dates of Treatment: _______________________________

☐ ER Records ☐ OP Reports ☐ Office/Clinic Visit

☐ Discharge Summary ☐ Radiology Reports ☐ H&P, Consults, Progress Notes

☐ Pathology Reports ☐Lab Reports ☐ Cardiology/Cardiovascular records

☐ Other: ____

The above information is released for the following purpose and that purpose only:

☐ Continuation of Care ☐ Legal Purposes ☐ Insurance Purposes

☐ Personal Reasons ☐ Employer Requirement ☐ Other: ___________________

_____________________________________ _________________________________

Print Patient Name Signature of Patient

____

Date

Name:______________________________ DOB:_______________ Date:_____________

Financial Responsibility

Heart and Vascular Wellness Center is committed to providing the highest level of professional medical care and personal service. For every commitment there is an obligation to provide quality care and service. Conversely, it is the patient/guardian's responsibility to meet their financial obligations. Since our clinic accepts many different insurance plans, it is impossible for us to know all covered benefits, co-pays, and deductibles for each plan. While it is our intention to assist you, it is still your responsibility to ensure that all services rendered by Heart and Vascular Wellness Center on your behalf are paid in full. If there are any questions please feel free to ask.

Failure to sign this agreement will result in us not being able to see you for your appointment.

1. **Insurance**: We participate in most insurance plans, including Medicare, Medi-Cal, PPO's and HMO's. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is **your** responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Copayments and deductibles**: All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered ***fraud***. Please help us in upholding the law by paying your co-payment at each visit. See explanations below of coverage you may have with your insurance.

   a. Co-Payment: A payment that is required at the time of service as a mechanism by which you share the cost of that visit with your insurance.

   b. Co-insurance: A payment that shares some of the overall cost of your care with your insurance. This is usually determined after the charges have been processed by the insurance company and an EOB has been issued. Insurances have set ratio, for example 70/30, where the insurance pays 70% of the allowed amount and you are responsible for 30%.

   c. Deductibles: These are amounts that are paid by you before any payments are made by your insurance. For example, a $500 deductible means that you are responsible for paying $500 of charges before insurance starts to pay. Once the deductible is "met" then your insurance will begin covering their portion of the allowed charges. Deductibles can be individual or per family. Deductibles usually reset every year.

3. **Non-covered services**: Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You are ***required*** to pay for these services in full at the time of the visit. Self-pay patients are ***required*** to pay for services at the time of visit.

4. **Proof of insurance**: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of a valid ID and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Name:________________________________ DOB:________________ Date:_____________

5. **Claims submission**: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not part of that contract.

6. **Coverage changes**: If your insurance changes, it is ***your*** responsibility to notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If we are unable to verify or have not received authorization for your visit, your appointment will have to be rescheduled. If your insurance company does not pay your claim, the balance will automatically be billed to you.

7. **Non-payment**: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise discussed with the office manager. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. **Missed appointments**: We have a 24-hour cancellation policy. We send out multiple reminders for your scheduled appointment. If you are unable to make your scheduled appointment please give the office a call. Our policy is to charge a fee of $35 for missed / no show appointments. These charges will be your responsibility. Please help us to serve you better by keeping your regularly scheduled appointment. If you are more than 10 minutes late, we may need to reschedule your appointment.

I accept full financial responsibility for all services provided by Heart and Vascular Wellness Center.

____
Patient Name (Print)

____ ______________________
Signature: Patient or Legal Guardian Date

If not signed by the patient, please indicate relationship: ______________________________

☐ **Refused to sign**

Name:___________________________________ DOB:__________________ Date:_______________

AUTHORIZATION

We feel it is important that you receive all test results. We please ask you to schedule a follow up appointment with Dr. Oshodi after your final test has been completed.

Please Mark One:

☐ Yes, I authorize Dr. Oshodi and his staff to leave me voicemails regarding healthcare information. (Fill out the form below)

☐ No, I **do not** authorize Dr. Oshodi and his staff to leave me voicemails regarding healthcare information. (Skip to next section)

Patient: Name: ____

Home Phone: ______________________________________

Cell Phone: _______________________________________

Please Mark One:

☐ Yes, I authorize Dr. Oshodi's office to inform a family member, relative, partner, or friend of my test results and/or appointments. (Fill out the form below)

☐ No, I **do not** authorize Dr. Oshodi's office to inform anyone other than myself of my test results and or/appointments. (Skip to signature below)

Patient's Contact Member: Name: ____

Home Phone: ______________________________________

Cell Phone: _______________________________________

Duration of Authorization:____

(if date is not filled, authorization will automatically expire after one year of dated signature below)

____

Signature of Patient/Guardian Date

Name:______________________________ DOB:_______________ Date:_____________