

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: _____ **PHONE #:** _____ **NAME OF LAB:** _____

PREFERRED LAB: _____ **PACEMAKER DEVICE NAME:** _____

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 judgment. 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

Print 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
- __ R __ L

- Chest muscle pain
- __ R __ L

Cardiovascular

- Chest /Arm pain or pressure
- Racing / Irregular heartbeat
- Fainting / Near fainting
- Discomfort in calf w/ walking
- Varicose veins ([see back page](#))
- 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

Female Patients

Last Menstrual Period: _____ Number of pregnancy: _____ Currently pregnant: _____

Deliveries: _____ Miscarriages: _____ Menopause (age): _____ Planning Pregnancy: _____

Print Name: _____ DOB: _____ Date: _____

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: _____

Allergies

Please list all allergies and reactions None

Allergy:

Reaction:

- | | |
|----------|-------|
| 1) _____ | _____ |
| 2) _____ | _____ |
| 3) _____ | _____ |
| 4) _____ | _____ |
| 5) _____ | _____ |
| 6) _____ | _____ |

Print Name: _____ **DOB:** _____ **Date:** _____

Past Medical History

Check all that apply

- | | | |
|--|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Convulsions/Seizure |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Gallbladder Stones | <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Autoimmune Disorder |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> HIV infection |
| <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetic Eye Problem |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Aneurysm of Aorta | <input type="checkbox"/> Cancer: |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Ulcer in Stomach |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Blood Clot in Lungs | <input type="checkbox"/> Other serious illness: |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke | _____ |

Social History

- Tobacco Use:** Never
 Current everyday
 Current some days If so, how often: _____
 Quit If so, when: _____
- Alcohol Use:** Never
 Current everyday
 Current some days 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			

**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

Date

Print Name

Patient Responsibilities

- Know the benefits and exclusions of your health insurance coverage.
- Present your ID card before receiving service, as well as any insurance card you may have been provided that is in effect.
- Know what medications, including over-the-counter products and dietary supplements. Why you are taking them and how to take them. Know what allergies you may have.
- Notify your provider of changes in address, phone number and insurance information in a timely manner.
- Make payment of all services or non-covered services and applicable co-payments at the time of service provided.
- Be respectful and courteous to clinic staff and other patients.
- Supply information that the clinic and its practitioners and providers need in order to provide care.

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.

No, I do not authorize Dr. Oshodi and his staff to leave me voicemails regarding healthcare information.

Please Mark One:

Yes, I authorize Dr. Oshodi office to inform or allow a family member, relative or partner, to have access to my medical records, test results, appointments and any information regarding my condition and treatment.

No, I do not authorize Dr. Oshodi's office to inform anyone other than myself of my test results and or appointments.

Patients Contact Member

Name: _____ Relationship to Patient: _____

Contact #: _____

Consent to share Cardiac notes to your Primary Care Physician? Yes No

Primary Care Physician Name: _____ Phone Number: _____

Signature of Patient : _____ Date: _____

Authorization for Release of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

Phone Number: _____

I hereby Authorize:

**Heart and Vascular Wellness Center
40770 California Oaks Rs. Suite A
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

Financial Responsibility

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.
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%.
 - b. **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.
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

Refused to sign