Northwest Houston Cardiology, P.A.

Aditya K. Samal, MD, FACC
Kris Vivek, MD, MRCP(UK), FACC
Tulsidas S. Kuruvanka, MD

Name_____SS#____-____-_____
Street Address_____D.O.B.____/_____/_____
City_____State_____Zip_____
Telephone Home _____Work _____Martial Status: S M W D
Referred By_____Phone_____
Spouse's Name _____Spouse's Employer _____
Spouse's Employer Adress_____
Emergency Contact_____ Phone_____ Relationship_____

PATIENT EMPLOYER INFORMATION

Employer Name_____ Phone_____
Address_____
Occupation_____

INSURANCE INFORMATION

Medicare # (if applicable)_____ Medicaid #_____
Primary Insurance Name_____ HMO PPO
ID #_____ Group #_____ Effective Date_____
Phone _____
Address_____
Secondary Insurance Name_____ HMO PPO
ID #_____ Group #_____ Effective Date_____
Phone _____
Address_____

INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. Signature_____ Date___

I hereby authorize N.W. Houston Cardiology to apply for benefits on my behalf for covered services rendered by his or her order. I request that payment from my insurance company be made directly to N.W. Houston Cardiology.

I certify that the information I have reported with regard to my insurance coverage is correct.

This authorization may be revoked by either me or my insurance company at any time in writing.

Signature_____ Date_____
Physician's Signature_____

N.W. HOUSTON CARDIOLOGY PATIENT HISTORY

Name_____ SS #_____

GENERAL MEDICAL INFORMATION

Describe any current medical problem/ reason for your visit _____.
Other Physicians currently treating you_____
Previous medical problems_____
Allergies_____
List any surgeries or hospitalizations. Dates & Hospitals (include number of miscarriages and births).
_____
_____
Do you smoke? _____ # of years_____ How much?_____
Interested in stoping? _____
Do you regularly drink alcohol? _____ How much? _____
Do you drink coffee? _____ How many cups per day? _____
Are you under a lot of pressure at work? _____ Please explain _____
Females only: are you pregnant, planning a pregnancy or nursing? _____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following? (please check all that apply).
Chest pain, pressure,tighting _____ Asthma_____ Kidney disease_____
Hypertension_____ Dizzy spells_____ Cancer_____ Diabetes_____
Shortness of breath_____ Heart attack_____ TB/ lung disorder_____
Stroke_____ Ulcers_____ Headrache_____ Arthritis_____ Anemia_____
Skin disorders_____ Memory loss_____ Depression_____
Other Problems? _____

HEPATITIS C RISK FACTOR

Blood transfusion before 1992_____ Contact with blood/ body fluids_____
Tattoos_____ Body piercing_____ Shared razor/ toothbrush_____
IV drug use_____

Immunizations & Date	**Family History**
(year last recived)	(name of family member)
Tetnus_____	**Hypertension**_____
Influanza_____	**Epilepsy**_____
Pneunomia_____	**Cancer**_____
Rubella_____	**Heart Attack**_____
Hepatitis_____	**Stroke**_____
	Diabetes_____

Advanced directives? _____
Would you like information @ Advanced Directives? _____

Physician's Signature_____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

Date of Service: _____ Social Security #: _____

I request and authorize _____ to release health care information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Information to be released:

____Emergency Room	_____Radiology Report	_____Lab Work
____History & Physical	____ Drug Alcohol Info	_____Billing Records
____Consults	____ Psychatric Info	_____HIV Results
____Operative Report	____ Cath Lab Film	_____Discharge Summery
____Other		

_____

This information is being release for the following purpose

_____Continued Care _____Insurance _____Disability Services

_____

I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it and that in ant event this authorization Shall expire 180 days from the date of my signature unless specified in writing here:

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE HUNDRED AND EIGHTY DAYS AFTER IT IS SIGNED.

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, N.W. Houston Cardiology may use and disclose protected health information (PHI) about me to carry out treatment, payment, and health operations (TPO). Please refer to N.W. Houston Cardiology's Notice of Privacy Practices for more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. N.W. Houston Cardiology reserves the right to revise its notice of Privacy practices at anytime. A revised Notice of privacy Practices may be obtained by forwarding a written request to:

N.W. Houston Cardiology
13325 Hargrave Rd., Suite 100
Houston, TX 77070

With my consent, N.W. Houston Cardiology may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in caring out TPO, such as appointments reminders, insurance items, and any call pertaining to my clinical care as long as they aren't marked personal and confidential.

I have the right to request N.W. Houston Cardiology restrict how it uses or discloses my PHI to carry out my TPO. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement/ by signing this form I am consenting N.W. Houston cardiology's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent N.W. Houston Cardiology may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Name

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1. As a courtesy to our patients, we agree to bill your insurance company. The Guarantor, however, is ul

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