OKLAHOMA HEART HOSPITAL PHYSICIANS

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 ☐ Heavy Cigar/Pipe Smoker
☐ Current Some Day Smoker ☐ Never Smoker ☐ Light Cigar/Pipe Smoker

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

PLEASE PRINT

OKLAHOMA HEART HOSPITAL
Outpatient Clinic

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?
❑ Asian ❑ African American ❑ Hispanic ❑ Caucasian ❑ Pacific Islander ❑ Native American ❑ 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

Patient's Nearest Relative (Other than Spouse)	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-F279PB (Rev. 9/11)	Original
OHHP-F279PB (Rev. 2/13)	Revision table added

Patient Name: _____

Admission Date: _____

MRN: _____

CONDITIONS OF ADMISSION

Assignment of Insurance Benefits: I hereby authorize payments from all insurance companies to be made directly to **OKLAHOMA HEART HOSPITAL, LLC** or **OKLAHOMA HEART HOSPITAL SOUTH, LLC**, hereinafter referred to as **"OHH,"** and **OHH PHYSICIANS, LLC**, hereinafter referred to as **"OHHP,"** for benefits otherwise payable to me. I understand that I am financially responsible to the hospital for charges not covered by this assignment. I certify that the above information in support of this claim is true and correct.

Medical and Surgical Consent: The patient, or his or her representative, hereby acknowledges the patient's need for hospitalization or treatment because he or she suffers from a condition requiring diagnosis and medical and/or surgical treatment. The undersigned requests and voluntarily consents to the patient's receipt of the usual Hospital services, as well as the diagnostic laboratory (such as testing of the blood and other bodily fluids), x-ray procedures, medical and/or surgical treatment, including administration of anesthesia judged to be necessary by the patient's attending physician, his assistants or other physicians designated by him. The Hospital is authorized to retain, preserve and use for scientific or teaching purposes, or dispose of at its convenience any specimens or tissue removed from the patient's body during hospitalization or treatment.

Payment Responsibility: The undersigned understands that the patient, or another person who specifically agrees to guarantee payment for the patient, is responsible for the payment of all charges of the Hospital or Physician relating to services rendered by the Hospital or Physician to the patient that exceed any third party coverage, including applicable coinsurance payments and deductibles and all amounts for which payment has been denied by any third party. There are other services that will be billed separately from the hospital bill including services performed by other physician specialists who perform services for your care and treatment while a patient at OHH. Amounts due from the patient to the Hospital prior to execution of this Agreement may, at the sole discretion of the Hospital, be consolidated with, and made a part of, the amount due hereunder. The patient shall pay all costs of collection in connection with the enforcement of this commitment, including reasonable attorney's fees and court costs incurred by the Hospital. You authorize personal contact from us or our third-party collector, via telephone or cell phone numbers provided to us, including line voice, text, auto dialed or prerecorded message.

Other Uses of PHI: I understand that in-hospital staff committees may utilize data relating to my condition in the course of studies for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality. I understand that should the recipients use or publish such information or material that my identity shall be confidential and shall not be revealed under any circumstances.

Provider Based Billing: When seeing an OHH healthcare provider for any type of outpatient services, you will see a change in the way you are billed. Under "Provider Based" status, OHH is required to bill provider services in two parts. When your medical services are completed, OHHP will submit a claim for the professional fee and OHH will submit a claim for the facility fee. You will receive two statements/bills for your services – one from OHH and one from OHHP. ☐ **N/A**

_____ **(Initial)** I acknowledge receipt of the Provider Based Medicare Outpatient Coinsurance Notice; actual liability will depend on services furnished. ☐ **N/A**

Notification of HIV Testing: The undersigned has been notified of the testing of the patient's blood for human immunodeficiency virus (also known as AIDS) if determined by the patient's attending physician. This is necessary (i) for determining the appropriate treatment and/or treatment procedures for the patient or (ii) for the protection of the attending physician and/or any employee or agent of the Hospital or the attending physician exposed to the bodily fluids of the patient in a manner which could transmit such disease. _____ **(Initial)**

Facility Directory: Unless I object, I understand that my name, location, general condition, and religious affiliations may be released to the clergy or to others who ask for me by name. ☐ **Agree** ☐ **Object** (If I object, I understand I cannot receive phone calls, deliveries, etc.)_____**(Initial)**

Acknowledgment of Notice of Privacy Practices: I have received/reviewed the "Notice of Privacy Practices" from OHH. If I have any questions, I know to contact the Privacy Officer whose information is provided to me in the "Notice of Privacy Practices". I understand that if I request a copy of this form one will be provided to me by the Registration staff. _____ **(Initial)**

Disclosure of Physician Interest: OHH has financial relationships with numerous Oklahoma physicians, some of whom have an ownership interest in the Hospital, and some of whom are paid by the Hospital for services they provide. If the physician who recommended the Hospital to you has a financial interest, and if his or her financial relationship with the Hospital concerns you, you may be treated at an alternative facility, if there is one available. If you would like to discuss your options for treatment at other facilities, or if you have any questions about this disclosure, please ask the person providing you with this form for assistance. A list of physician owners has been provided to me. _____**(Initial)**

Electronic Messages Consent: Your health is important to OHH. In order to provide you with the best possible care, OHH, its agents or affiliates may contact you with marketing information, health information, appointment reminders, billing, collections, and other account activities by **telephone, autodialed calls, text, email, robocalls, and artificial, prerecorded voices, and other electronic messages**. It is not possible to guarantee that any transfer of information over text messaging is 100% secure. As a result, OHH cannot guarantee the absolute security of information sent via text message. By permitting OHH to transmit information to you through text messaging, you accept the risk that the transmission is not secure, and that your information may be exposed to a third party. Text message and data rates may apply to messages sent by OHH and multiple texts may be sent each day. I ☐ **Agree** ☐ **Object** to receiving text message and other electronic messages sent by OHH or third parties on OHH's behalf. I understand that I can op-out of texting at any time by replying STOP to any text message sent by OHH or a third party on behalf of OHH.

THE UNDERSIGNED CERTIFIES THAT SHE/HE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

_____ _____

Date Patient, Patient's Agent or Representative

_____ _____

Witness Agent or Representative's Relationship to patient

Date & Version #	Change Summary
07/30/2020 Ver 9	Added Text Consent
08/26/2020 Ver 10	Multiple Changes

OKLAHOMA HEART HOSPITAL

Outpatient Clinic

Release of Protected Health Information To Family Members and Persons Involved in Patient's Care

With your permission, OHHP 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

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-F268PB (Rev. 2/13)	Added revision table
OHHP-F268PB (Rev. 3/13)	Added verbal/witness