Heart Center of Nevada
PATIENT HISTORY

Today's Date: **Name:** **DOB:** / / **Age:**

Nurse only: B/P ________________ **SPO2**______________ **Ht.**__________ **Wt.** _____________
Chief Complaint: ____
____
____
____

Referring / Primary Care Provider? ____

PLEASE ANSWER THE FOLLOWING

Have you experienced any of the following?

Chest pain/discomfort? Yes__ No__ Last Episode? ________________________________
Palpitation/flutter? Yes__ No__ Last Episode? ______________________________________
Shortness of breath? Yes__ No__ Last Episode? ___________________________________
Dizziness/light headed? Yes__ No__ Last Episode? _________________________________
Swelling in legs/feet? Yes__ No__ Last Episode? __________________________________
Heart Attack? Yes__ No__ When/Where? ____
Angiogram (Heart Cath) Yes__ No__ When/Where? _________________ Stents? __________
Bypass? Yes__ No__ When/Where? ____
High blood pressure? Yes__ No__ for how many years? ______________________________
High Cholesterol? Yes__ No__ for how many years? _________________________________
Diabetes? Yes__ No__ for how many years? ____________________________________
Atrial Fibrillation? Yes__ No__ for how many years? _______________________________
Congestive heart failure? Yes__ No__ for how many years? __________________________
Ulcers? Yes__ No__ Bowel/urinary problems? Yes__ No__ Headaches? Yes__ No__
Have you been hospitalized in the past 6 months? Yes__ No__ When /Where/ Why?
____

Oher past medical problems/diagnosis/surgeries/cancer? ___________________________
****

Family History	**Heart Disease**	**Diabetes**	**High Blood Pressure**
Father	Yes No	Yes No	Yes No
Mother	Yes No	Yes No	Yes No
Siblings	Yes No	Yes No	Yes No
Grandparents	Yes No	Yes No	Yes No

Personal History: Single______ Married ________ Divorced ________ Widow ________
Work History: Disabled ______ Working ______ Retired ______ Industry? ____________
Do you Smoke? Yes___ No___ Never ___ Former ___ How much/ How long? _________
Do you Drink? Yes___ No___ Never ___ Former ___ How much/ How long? _________
Are you allergic to any medication? Yes___ No___ if yes what? ______________________________
Are you allergic to shellfish? Yes___ No___ Are you allergic to Iodine? Yes___ No___ Rev 10/24/2022/nt

Heart Center of Nevada

Pharmacy Record

Patient Name: ____ DOB: __________________

Medication Allergies____

Pharmacy Name/ Phone/ Address ____

CURRENT MEDICATIONS

Drug Name	Strength	Frequency

Vein Center of Nevada

PERIPHERAL ARTERIAL DESEASE (PAD) SCREENING AND ASSESSMENT

Name__________________________________ DOB _________________ Date__________________

1. Do you experience aching, cramping or pain in your arms, legs, thighs or buttocks? When you walk or exercise? ______________________ Yes No
2. If you answered YES to question Number 1, does the pain subside with rest? Yes No
3. Do you have numbness and tingling in the arm or lower legs or feet? Yes No
4. Are your fingers or toes pale, discolored or bluish? Yes No
5. Are your hands or feet cold to the touch? Yes No
6. Do you have any painful sores or ulcers on legs or feet that don't heal? Yes No
7. Are you currently taking any medications for hypertension?
   If Yes, how many medications are you taking ___________________________________
   How long have you been taking these medications? _____________________________
8. Do you now or have you ever smoked cigarettes? Yes No
9. Do you have emphysema? Yes No
10. Do you have high blood pressure? Yes No
11. Have you had any problems with your kidneys?
    If Yes, please describe ____
12. Do you have high cholesterol? Yes No
13. Do you have Diabetes? Yes No
14. Do you exercise on a regular basis? Yes No
    If Not, what keeps you from exercising? ____
15. Are you over the age of 50 years old? Yes No
16. Do you have family history if diabetes or cardiovascular problems? Yes No
17. Have you ever experienced a stroke, mini stroke or transient ischemic attack? Yes No
18. Any previous cardiovascular surgeries? Yes NO

Name: ____ DOB: ______________________

NEW PATIENT INFORMATION

Referred by: ______________________________ **Primary care Doctor:** ____________________

Patients Name____ DOB: ____________________

Address _____________________________________ City _____________ State ________ Zip _________

Home Phone ___________________________

Cell # _________________________________

Emergency Contact
Name _________________________________
Relationship ___________**Phone** _______________

Email Address ______________________________

Social Security# ________________________ Marital Status ______________ Occupation__________________

Race: White * Black or African American * Asian * Native Hawaiian or other * American Indian or Alaska native

Ethnicity: Latino/Hispanic * Not Hispanic or Latino * Other * Refused * Not Reported

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PRIMARY INSURACE COVERAGE

Insurance Company _______________________________ Policy#__________________________________

Name of Insured ________________________ DOB ____________ SS #____________________________

Insured's Employer______________________ Relationship to Insured: Self Spouse Dependent

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SECONDARY INSURACE COVERAGE

Insurance Company _______________________________ Policy#__________________________________

Name of Insured ________________________ DOB ____________ SS #____________________________

Insured's Employer______________________ Relationship to Insured: Self Spouse Dependent

AUTHORITY AND ASSIGNMENT OF INSURANCE BENEFITS. I authorize the release of any medical information necessary to process this claim and request that payment of medical benefits be paid directly to Heart Center of Nevada for services provided.

SIGNED ____________________________________ **DATE** ___________________________

Heart Center of Nevada

ATTENTION PATIENT

IT IS THE RESPONIBILITY OF THE PATIENT/ INSURED TO KNOW WHETHERE THE DOCTOR YOU ARE SEEING FOR MEDICAL SERVICES IS A PROVIDER ON YOUR INSURANCE AND TO PROVIDE A REFERRAL, IF NECESSARY, UPON ARRIVAL. IF NOT, YOUR **APPOINTMENT WILL BE RESCHEDULED.**

YOU AS THE INSURED ARE RESPONSIBLE FOR ANY CO-PAYS, CO-INSURANCE OR DEDUCTIBLE AT THE TIME OF SERVICE.

IF OUR OFFICE IS NOTIFIED BY YOUR INSURANCE COMPANY FOR INELIGIBILILY OF BENEFITS, OR THAT YOU ARE NO LONGER INSURED, **YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.** YOU AS THE PATIENT ARE ALSO RESPONSIBLE TO PAY YOUR DEDUCTIBLE IN FULL.

IF THERE ARE ANY PROBLEMS, YOU WILL BE SUBJECT TO COLLECTIONS.

SIGNED: ________________________________ **DATE:** ______________________

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I, ______________________________________, authorize Heart Center of Nevada to release information either in writing or verbally relating to my medical condition to the following people:

Name	Relationship
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________

Signature: _____________________________________ Date: ________________

REQUEST FOR RELEASE OF MEDICAL RECORDS

_To: ____

Address: _______________________ City __________________ State__________ Zip____________

Phone: ________________________ Fax: ______________________

I hereby request that my medical records be released to:

Physician's name (Print): ________________ ________________________________

700 Shadow Ln #240 Las Vegas, NV 89106 PH: 702-384-0022 **FX: 702-384-0529**	3196 S Maryland Pkwy #207 Las Vegas, NV 89109 PH: 702-732-0022 **FX: 702-732-4532**	1815 E Lake Mead Blvd #110 N. Las Vegas, NV 89030 PH: 702-642-9010 **FX: 702-642-0717**	5380 S Rainbow Blvd #226 Las Vegas, NV 89118 PH: 702-260-0022 **FX: 702-260-0200**
6850 N Durango Rd # 312 Las Vegas, NV 89149 PH: 702-433-0022 **FX: 702-433-0322**	653 Town Center Dr. Suite #410 Las Vegas, NV 89144 PH: 702-804-0022 **FX: 702-331-9719**	10001 S. Eastern Ave #403 Henderson, NV 89052 PH: 702-754-0622 **FX: 702-476-2161**	

Patient's name (Print): ____

Patient's Signature: ____

Date of Birth: __________________________ SSN: ___________________________

Patient's Address: ____

City: _________________________ State: _______________ Zip: ______________

○ **Request all records**_____________________________________

○ **Requesting only: Echo, Nuclear stress test, Carotid u/s, Heart Cath and Dr.'s Notes**

HIPPA Notice of Privacy Practices

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is now subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosed of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive and accounting of certain disclosures we have made, if any of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdrawal as provided in this notice.

Complaints:
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**
This notice was published and becomes effective on/or before **April 14, 2003.**
We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at 702-384-0022.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ______________________________ Signature: __________________________________ Date: ___________

Heart Center of Nevada

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control our protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. **Treatment**: We will use and disclosed your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. **Payment:** Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical student, licensing and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law: Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement; Coroners, funeral Directors, and Organ Donations; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Users and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's Practice has taken an action in reliance on the use or disclosure indicated in the authorization. Rev 09/25/2022