Southern Mississippi Heart Center, PA

Patient Registration Form

NAME: _____

Mailing Address: _____

_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ SSN: _____ Sex: _____ Marital Status: _____

Employer & Phone: _____

Spouse Employer & Phone: _____

Spouse Name, Phone, & DOB: _____

Primary Insurance: _____

Group #: _____ ID#: _____

Secondary Insurance: _____

Group #: _____ ID#: _____

Emergency Contact: _____ Phone #: _____

Email Address: _____

(By giving us your email address it will allow you to access your medical records through our Patient Portal.)

Name and Phone # of your Pharmacy: _____

Referring Physician: _____

SOUTHERN MISSISSIPPI HEART CENTER

HISTORY AND PHYSICAL

Name:_____ AGE:_____

Today's Date: _____ Date of Birth: _____

Chief Complaint (Why are you here)

_____

_____

A. Do you have chest pain? YES or NO

1. When did you first have chest pain? _____

2. How long does it last? 1min 5min 15min 30min 1hr other

3. How often do you get chest pain? Daily Weekly Monthly Yearly other

4. Has your chest pain been getting any worse? YES or NO

How is it worse? _____

5. Does the pain radiate to any other parts of the body? YES or NO

To where? _____

6. Please circle any symptoms that you have:

Pressure Burning Tightness Sharp other_____

7. Please circle any conditions that make it worse:

Physical activity Cold weather Stress Deep breathing

8. Please circle what makes it better:

Rest Nitroglycerin (how many _____) Nothing

B. Do you have shortness of breath? YES or NO

1. When did you first experience shortness of breath? _____

2. About how long does it last? 1min 5min 15min 30min 1hr Other

3. Please circle any conditions that make it worse:

Physical activity Lying down It happens at rest

4. Do you wake up at night gasping for breath? YES or NO

5. How many pillows do you sleep with? One two three

C. Do you have palpitations (can you feel your heart beating)? YES or NO

1. When did you first start having palpitations? _____

2. How long do the palpitations last? 1min 5min 10min 15min 30min 1hr Other

3. Please circle how your heart beat feels :

Regular or Irregular Slow or Fast

4. Do you get short of breath when you get palpitations? YES or NO

5. How often do you get palpitations? Hourly Daily Weekly Monthly Other

6. How are they changing? More often Less often No change

D. Please check any symptoms that you have:

- o Nausea
- o Swelling around the ankles
- o Cold sweats
- o Double vision When? _____ For how long?_____
- o Temporary paralysis When? _____ For how long? _____
- o Dizziness When? _____ For how long?_____
- o Cramps in your legs while walking. Please circle one

Right leg Left leg Both legs

How far can you walk before you get cramps in your legs. Please circle one

One block Several blocks One mile Other

Other problems: _____

E. Please check any of the following you have now or had in the past?

- o Diabetes Since what age? _____ Controlled with Insulin or pills? _____
- o High Cholesterol Since what age? _____ Controlled with diet or medication? _____
- o Heart attack 1st 2nd 3rd
- o Heart Failure Since when? _____

When was the last time you were hospitalized with failure? _____

- Stroke 1st _____ 2nd _____
- Blood Clots when? _____ what part of the body? _____
- Pacemaker when? _____
- Rheumatic Fever when? _____
- Lung Disease (emphysema, COPD) Since what age? _____
- High blood pressure since what age? _____ Controlled with medications? _____

F. What medications are you taking?

Name	Dose	How often

G. Allergies:

_____

H. Social History:

1. Please check any of the following that apply to you:

- Current smoker Since what age? _____ PKS per day _____
- X-smoker Quit at what age? _____ Years smoked _____ PKS PER day _____
- Alcohol How often _____ How many drinks _____
- Drugs What _____ How often _____
- Caffeine Cups or sodas per day _____

2. Please circle one:

Single Married Divorced Widowed

3. Number of children _____

4. Occupation _____

5. Last menstrual cycle (age and date) _____

Hormone replacement? YES or NO

I. Surgical History:

Surgery	Date	Where surgery was done

J. Family history of Heart Disease:

	What did they have?	How old when first had symptoms?	If deceased at what age?
Father			
Mother			
Brother			
Sister			
Other			

K. Have you ever had...

Test	Date	Where was it done?
Echocardiogram (ultrasound of the heart)		
Exercise Stress Test (treadmill)		
Chest Xray		
EKG		
Holter monitor		
Cardiac Cath		
Electrophysiological Study		
Carotid Ultrasound		

I. Any other information you would like to share:

_____

_____

_____

SOUTHERN MISSISSIPPI HEART CENTER, P.A.

3704 Bienville Blvd. Suite B
Ocean Springs, MS 39564
228-872-4040 (fax) 228-875-2387, 228-875-2373 or 228-872-3612

4300 Hospital St. Suite 102
Pascagoula, MS 39581
228-762-1002 (fax) 762-1012

Patient Name:_____ Date of Birth: _____

Social Security Number: _____Phone: _____

Patient Address: _____

_____

I, hereby authorize Southern Mississippi Heart Center, P.A. to request or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Please list the Primary Care and Any Other Physicians you would like us to share your records with: _____

_____

To/From: _____

Fax: _____

Disclose the following PHI for treatment dates _____to_____

_____Most Recent EKG _____ History and Physical _____ Discharge Summary

_____ Vascular _____Operative Report _____ Progress Notes (Last 2)

_____Echo _____ Stress Test _____ ER Report(s)

_____ Lab (Example BMP, Lipid / Liver _____ X-Ray report _____Entire Chart

_____ Other Specified (Heart Caths / Stents, Pacemaker Checks, Pacemaker Implants) _____

The above information is disclosed for the following purpose:

_____Medical Care _____ Legal _____Insurance _____Personal _____ Other

_____ I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV or genetic information.

This authorization shall expire 12 months from the date signed unless otherwise stated _____.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Southern Mississippi Heart Center, P.A. I understand that the revocation will not apply to information that has already been released pursuant to this authorization.

The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

I have read the above and I hereby authorize the disclosure of the PHI (protected health information) as stated:

_____ _____

Signature of Patient/Legal Representative Date

If signed by legal representative relationship to patient: _____

_____

Southern Mississippi Heart Center, P.A.

Patient Agreement for Communications

I, _____, understand that as part of my health care Southern Mississippi Heart Center, P.A. will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of special precautions and measures that I need to follow prior to a procedure, to follow-up after a procedure, etc. I hereby authorize Southern Mississippi Heart Center, P.A. to contact me in the following ways:

_____ Home Phone (voice mail) Number: _____

_____ Office Phone (voice mail) Number: _____

_____ Cell Phone (voice mail) Number: _____

_____ Fax Number: _____

_____Email Email Address:_____

I authorize Southern Mississippi Heart Center, P.A. to speak with the following person/s and release information on my behalf:

_____

_____

_____

I Authorize Southern Mississippi Heart Center, P.A. to remind me of my appointments by text message. _____ Yes _____ No

I Authorize Southern Mississippi Heart Center, P.A. to leave voicemail messages reminding me of my upcoming appointments. _____ Yes _____ No

I Authorize Southern Mississippi Heart Center, P.A. to leave a voicemail message with my normal test results and Prescription refill information. _____ Yes _____No

I understand that Southern Mississippi Heart Center, P.A. will use the minimum necessary information needed when they communicate with me indirectly. I understand that I can revoke or amend this agreement at any time. Any revocation or change will not apply to communications already complete.

Patient Name: _____ Date of Birth: _____

Patient ID: _____ SSN: _____

_____
Date

_____
Print Name

_____
Signature of Patient or Authorized Party

_____
Relationship to Patient

Southern Mississippi Heart Center, P.A.

Acknowledgement of Receipt of Privacy Practices

I, _____ have received a copy of Southern Mississippi Heart Center, P.A. Notice of Privacy Practices.

_____
Date

_____
Print Name

_____
Signature

OFFICE USE ONLY

On _____ 20___ at_____ (AM/PM) we made a good faith attempt to obtain a written acknowledgement of receipt of our NPP, but acknowledgement could not be obtained because of the following reasons:

_____ Patient refused to sign

_____ Communication barriers prevented obtaining a receipt

_____ An emergency prevented obtaining a receipt

_____ Other: _____

Assignment of Benefits/Authorization to Release Medical Information/Financial Responsibility

AUTHORIZATION FOR TREATMENT: This is to certify that I/we undersigned , authorize and consent to the administration of treatments that are deemed necessary by Southern Mississippi Heart Center, PA.

I hereby assign and authorize direct payment to Southern MS Heart Center of all insurance or other benefits otherwise payable to me for medical service provided by any member of this group practice. To the extent necessary to determine liability and to obtain payment, I hereby authorize Southern MS Heart Center to release portions of my record, including my medical record, to any person, organization or agency which may be liable for reimbursement of medical services provided to me. I understand that I am financially responsible for charges not covered by my insurance plan. Should my account become delinquent and referred to an attorney or collection agency for collection, I understand that I will be charged for all attorney fees and collection expenses and may also be charged interest at the maximum rate allowed by law.

PRINT NAME_____Date:_____

Signature:_____

Witness:_____Date:_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our policies and assignment of benefits, but acknowledgement count not be obtained because:

- ☐ *Individual refused to sign
- ☐ *Communication barriers prohibited obtaining the acknowledgement.
- ☐ *An emergency situation prevented us from obtaining acknowledgement
- ☐ *Other (please specify) _____

Patient was provided with a larger readable version at the time of signing.