Welcome to Our Practice!

Dear New Patient,

Welcome and thank you for selecting Florida Heart Associates, P.L. We appreciate the confidence and trust you have placed in us.

It is important to understand that delivering care requires the effort of both you and our professional staff. We will do our part to diagnose, treat and care for you in a friendly and considerate manner. It is your responsibility to listen to your physician, follow his/her instructions, communicate with the practice, keep your appointments, and pay for the services you received.

We are providing several documents for you to read, sign and return. We bill your insurance as a convenience to you and having accurate up-to-date information is necessary and required to provide the care you seek. We bill your insurance as a convenience to you, thus the insurance assignment and financial policies explain your personal responsibility for payment, including but not limited to co-payments, deductibles, in-network and out-of-network services. The patient demographics and new patient history forms assist us to establish personal medical information relevant to your medical care. Should you have questions regarding your account, we provide financial counselors to assist in answering your questions. Please feel free to speak to a financial counselor when you call or arrive for your appointment.

You may receive telephone calls to remind you of your appointment and ask questions about your medical history. Please cooperate with the practice by providing the information requested and keep your scheduled appointments. If you find that you will not be able to keep your appointment, please call our office to reschedule at least 24 hours before the appointment time.

Everyone here at Florida heart Associates, P, L. wants you to receive the very best care and return to a healthy lifestyle.

Sincerely,

Florida Heart Associates, P.L.

Please Fill Out The Following Forms & Return within 1 week via:

1. **Email:** **medicalrecords@flaheart.com**
2. **FAX #:** **239-278-0404**
3. **MAIL**: *Florida Heart Associates*
   ATTN: Medical Records 1550 Barkley Circle
   Fort Myers, FL 33907

FLORIDA HEART ASSOCIATES

FHA NEW PATIENT HISTORY

Name _____ **Phone #**_____

Address: _____

DOB: _____ **Allergies:**_____

Reason for Referral: _____ **Referred by:**_____

PRESENT CONCERNS: Pls circle.

YES	**NO**	**Chest Pain**	**How Long?** _____
YES	**NO**	**Difficulty Breathing**	**How Long?** _____
YES	**NO**	**Palpitations**	**How Long?** _____
YES	**NO**	**Fainting/Lightheadedness**	**How Long?** _____
YES	**NO**	**Swelling in Legs**	**How Long?** _____
YES	**NO**	**Cramps/fatigue in Legs while Walking**	**How Long?** _____

MEDICATIONS:

DRUG NAME	DOSAGE	ONCE A DAY / TWICE A DAY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19		

FLORIDA HEART ASSOCIATES

PAST MEDICAL HISTORY:

YES NO High Blood Pressure

YES NO Diabetes

YES NO High Cholesterol

YES NO Thyroid Disease

YES NO Bleeding Issues

YES NO Valve repair or replacement

YES NO Atrial fibrillation (AFib)

YES NO Peripheral artery disease

YES NO Stroke

YES NO Coronary artery disease/heart attack/Stents/Bypass

YES NO Kidney Disease

YES NO Rheumatic Fever

SOCIAL HISTORY:

Currently smoker: _____

Packs per day: _____

Years smoked: _____

Past Smoker: _____

Never Smoked: _____

Vap: _____

Alcohol Use: _____

Caffeine Use: _____

Exercise: YES NO

FAMILY CARDIAC HISTORY:

	Relation:	*Approximate Age Diagnosed*
Heart attack/stents/Bypass		
Atrial Fibrillation (AFib)		
Died suddenly without known cause		
Aneurysm (Brain, Aortic, Coronary)		

CARDIAC SURGERIES: ***(This includes bypass, stents, ablations, valve replacement- mechanical or tissue, valve repair)***

	When?	**Hospital? City?**
1.		
2.		
3.		

CARDIAC IMAGING	***WHEN:***	***WHERE:***
Last Stress Test	_____	_____
Last Echocardiogram	_____	_____
Cardiac Catherization	_____	_____
Ablation	_____	_____
Last Coronary calcium Score	_____	_____
Last Coronary Cat SCAN	_____	_____
Cardioversion	_____	_____
Holter or ECAT monitor	_____	_____

Recent CARDIAC Hospitalization: WHEN: _____ WHERE: _____

Previous Cardiologist Name: _____

City and State of Previous Cardiologist: _____

Phone#: _____ FAX#_____

Is there any other information that you think your doctor should know?

We thank you for taking the time to fill out this patient package. We look forward to seeing you in our practice!

Authorization for Release of Medical Record Information

I hereby authorize Florida Heart Associates (FHA) to obtain my protected health information, by requesting a copy of my medical records including office notes, labs, imaging, procedures pertaining to my health condition from my Primary Care Physician, Previous Cardiologist or Other Specialist as listed below.

PCP: _____ **Previous Cardiologist**:_____

Other Specialist/Doctor: _____

As described in the notice of privacy practices of Florida heart Associates, PL, I understand that I may revoke this authorization in writing at any time, except to the extent that the action have been taking as outlined by this authorization; the revocation must be in writing and sent to Florida Heart Associates, 1550 Barkley Cir., Fort Myers, FL 33907.

Patient Name: _____ Date of Birth: _____

Patient's Signature: _____ Today's Date: _____

********** **FHA STAFF TO FILL OUT BELOW**********

FHA Staff Requests the Release of Medical Records within the last 5 years requested:

__ All Catherization __ Most recent Echocardiogram ___ Most recent Stress test

__ Most recent Labs/ INR/Lipids __ Last Office Note ___Heart Surgery or Vascular Surgery

__ Most recent Vascular Imaging ___ Most recent MUGA ___ Most Recent Pacer Check

__ Most recent Event or Holter Monitor ___ Most recent EKG ___ Other: _____

Please send the following information to FHA via:

1. EMAIL: **medicalrecords@flaheart.com**
2. FAX: **239-278-0404**
3. MAIL: **Florida Heart Associates, PL**
   Attn: FHA Abstraction
   1550 Barkley Circle
   Fort Myers, FL 33907

Name of FHA Staff Requesting Information: _____ Date: _____

LIVING WILL

Medicare and Private insurance companies require us to participate in different quality programs. One of these requirements is to ask our patients if they have an advanced directive/living will for healthcare. This often includes a patient advocate to express your wishes when you are unable

Patient name: _____ DOB:_____

_____ YES, I have a living will that explains my desires regarding medical treatment in circumstances when I am no longer able to express informed consent. *Please bring a copy to your next appt.*

_____ NO, I do not have one and I do not want any more information

_____ NO, but I would like more information on where to get one.

Living Will/Advanced Directive resources

1. **Department of Elder Affairs:**

   For information on living wills or advance directive, please contact the Department of Elder Affairs helpline at * 850) 414-2000. They can refer you to your county resource.

2. **Florida Senior Legal Helpline: 888-895-7873 (some income restrictions apply)**