IBRAHIM HEART CLINIC

New Patient Registration Form **Date:**_____

Email address: _____

Last Name:_____First _____ MI_____

Address_____

City_____State_____Zip_____

Sex: F____M____ D.O.B _____Social Security #_____

Home Ph:_____Work Ph:_____Cell/other _____

Marital Status: _____ Single _____Married _____Divorced / Separated _____Widowed

If married, Spouse's name _____

Do we have permission to:

Leave a message on your answering machine at home? YES_____ NO_____

Leave a message at your place of employment? YES _____ NO_____

Discuss your medical condition with any member of your household? YES _____ NO_____

If yes, whom? _____Relationship_____

Emergency Contact:

Name:_____Relationship_____

Phone:_____ Phone:_____

Address_____City_____State_____Zip_____

Occupation_____

Cardiovascular Specialists seen in the past? Who? _____ When?_____

Referring Physician:_____Phone:_____

Address:_____City_____State_____Zip_____

Please List Current Physician's you see:

Family/Primary Care:_____ Phone:_____

Pulmonologist:_____ Phone:_____

Nephrologist:_____ Phone:_____

Oncologist:_____ Phone:_____

Dialysis: M T W TH F S Location:_____Phone:_____

We are required to request the following information. The Federal Administrative Reporting Agency requests that we provide this information for statistical purposes only. Your Participation is optional. Please take a moment to complete the following questions. Thank you.
****If you choose not to participate please initial here: _____**

Race: American Indian/ Alaskan Native	Ethnicity: Hispanic / Latino	Preferred Language: English
Native Hawaiian	Not Hispanic or Latino	Spanish
Asian		French
African American/ Black		Creole
Caucasian / White		Other_____

Do you have a living will or other advanced directive? Yes___ NO____

INSURANCE INFORMATION

Do you have Medicare: Yes___ NO____ Is it your primary Insurance Yes_____ NO _____
Do you have Medicaid: Yes ___ NO____ Is it your primary Insurance Yes_____ NO _____

Primary Insurance Company_____

Address_____City_____State_____Zip_____
Members Insurance ID# _____ Group #_____
Name of Insured if other than patient_____
Relationship to Patient _____
Insured D.O.B_____ SS# _____

Secondary Insurance Company: _____

Address _____City _____State _____Zip_____
Members Ins. ID# _____Group #_____
Name of Insured if other than patient _____
Relationship to Patient _____
Insured D.O.B_____SS#_____
How did you hear about our practice? _____
Print Name: _____

Patient Signature: _____Date_____

******THERE WILL BE A $25.00 CHARGE FOR ALL INSURANCE /FMLA /DISABILITY PAPERWORK, AND HAVE 20 WORKING DAYS TO COMPLETE. MEDICAL RECORDS WILL HAVE A $25 FLAT FEE FOR ALL RECORDS RELEASE TO PATIENTS UPON SIGNING A RELEASE AND NO LONGER WITH IHC OFFICE.*****

Medical History

Please check to the right of each item	YES	NO	DON'T KNOW	Please check to the right of each item	YES	NO	DON'T KNOW
Asthma J45.909				HIV Z21			
Aneurysm Z86.79				Irregular Heartbeat I49.9			
Angina 120.9				Kidney Artery Angio/Stent Z95.828			
Shortness of Breath R06.02				Kidney Failure N19			
Artery Clot V12.59				Kidney Stone N20.9			
AFIB 148.91 Aflutter 148.92				Leg or Arm Angioplasty/ Stent Z98.89			
Blood or Clotting disorder V12.3				Leg I82.402 /I82.401 Arm clots I82.609			
Bronchitis J40 Emphysema J43.9				Liver K76.9			
Cancer Type _____V10.9				Lung Clot Z86.718			
Carotid Stent V43.4				Narcolepsy G47.419			
Chest Pain R07.9				Peptic Ulcer K27.9			
CHF I50.9				P.V.D. I73.9			
CAD I25.10				Prostate N42.9			
Diabetes How long? _____ E11.9				Rheumatic N42.9			
Gallbladder K82.9				Seizures G40.909			
Heart Attack (MI) I21.3				Sleep Apnea G47.30			
Hemodialysis Z99.1				Stomach Artery Angio/Stent Z95.828			
Hepatitis K75.9				Thyroid Disease E07.9			
Hypertension I10				Stroke I63.9 CVA I67.89			
High Cholesterol E83.9				Valvular Heart Disease I35.9			

Allergies

Do you have allergies to drugs, food, latex, dye? ____Yes ___No

Allergy –List medication, food, latex, dye, etc.	Reaction – rash, short of breath, hives, itching, etc.

Social History and Lifestyle

Alcohol Use	YES _____	NO_____	Beer___ Wine___ Liquor__
Smoking/ Tobacco Use 305.1 Profession Marital Status Living Status	YES_____ Working___ Married___ Spouse___	NO____ Retired____ Single____ Alone___	Number of years ___ Packs per day___ Unemployed_____ Divorced_____ Seperated_____ Other_____
Diet	YES_____	NO____	What Type?
Caffeinated Beverages	YES_____	NO____	How many daily?
Exercise	YES____	NO____	How many days a wk?___ how long?____
Substance Abuse	YES____	NO____	Type of Drug Dependency?
Military ?			Branch?

Current Medications

List all vitamins, prescription medications, and over-the-counter medications

*****Bring ALL Medications in their original containers to every appointment*****

Medication Name	Dosage	How often do you take?	Prescribing Physician

Past Surgeries & Procedures

Past Surgeries/ Procedures	**YES**	**NO**	**DON'T KNOW**	**Past Surgeries/ Procedures**	**YES**	**NO**	**DON'T KNOW**
Ankle Z96.669				AICD/ DEFIB Z95.810			
Appendectomy Z90.49				Aortic Aneurysm Repair Z98.89			
Back Z90.10				Cardiac Catheterization Z98.89			
Breast Z98.49				Cardiomyoplasty			
Cataract Z98.49				Cardioversion Z98.89			
Gallbladder Z90.89				Coronary Angioplasty Z98.61			
Gastric Bypass V45.86				Coronary Artery Bypass Z95.1			

Past Surgeries/ Procedures	YES	NO	DON'T KNOW	Past Surgeries/ Procedures	YES	NO	DON'T KNOW
Hernia Z91.49				Coronary Revascularization Z95.1			
Hip Z96.49				EP Study			
Hysterectomy Z90.79				Heart Transplant			
Intestinal Z90.49				Heart Valve Surgery Z94.1			
Knee Z96.659				Homograft Replacement Z95.4			
Lap Band Z98.84				ICD Lead Extraction T827XXA			
Prostate Z98.84				Pacemaker Implant Z95.0			
Sleep Apnea Surgery V90.89				RF Ablation Z98.89			
Tonsils Z90.89 Adenoids Z90.89				Valvuloplasty Z98.89			

Any Family History of Cancer, Diabetes, High Blood Pressure, Heart Disease, Heart Attack…etc..??? Please list any:

_____

_____

_____

_____

_____

**Our cardiovascular specialists have privileges at Baptist Medical Centers, Baptist South, Memorial Hospital Jacksonville, Orange Park Medical Center, Specialty Hospital, Brooks Rehabilitation Hospital, St. Vincent's Medical Center Southside and Flagler Hospital.

If you or your family members are admitted to these hospitals, please ask your nurse or administration or your doctor to call here at Ibrahim Heart Clinic so we may provide you with the continuous excellent care you always enjoyed with our group. We are on call for our patients 24/7 at these locations.

Print Name: _____

Signature: _____

Date: _____

No-Show and Cancellation Policy

We understand situations arise in which you must cancel your appointment. Therefore, we require that you provide adequate notice which will allow another patient access to timely medical care.

A "NO SHOW" is someone who misses an appointment without calling 24 hours in advance to cancel. Patients who No-Show three (3) or more times in a 12-month period, may be dismissed from the practice thus they will be denied any future appointments.

Office and testing appointments which are cancelled with less than 24 hours notification or no notice will be subject to a $25.00 cancellation fee.

Patients who do not show for their scheduled **Nuclear Stress Test and/or Echocardiogram** or those who fail to notify the office at least 24 hours prior to their appointment will be subject to a $100.00 cancellation fee.

The cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Office Manager.

We look forward to continuing our mission to provide the best healthcare in Northeast Florida and we thank you for choosing us as your healthcare partner

My signature below indicates that I have read and understand these policies.

_____ _____

Patient Name (Please print) Date of Birth

_____ _____

Patient Signature Date

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

e-Prescribing is defined as a physician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Ace (MMA) of 20031isted standards that has to be included in an e-Prescribe program. These include:

- Formulary and benefit transactions -Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions-Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification -Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Ibrahim Heart Clinic can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Ibrahim Heart Clinic to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Pharmacy Name:_____

Phone Number:_____

Address: _____

Patient Signature:_____

Date:_____

IBRAHIM HEART CLINIC

EPWORTH SLEEPINESS SCALE

Date: _____

Patient: _____ DOB: _____

Are you currently using a CPAP? ___ Yes ___ No Do You have sleep Apnea? ___ Yes ___ No

Rate your sleepiness as:
0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

How likely are you to doze off or fall asleep in the following situations? Use the sleepiness scale to choose the appropriate number for each situation.

1. Sitting and reading _____
2. Watching TV _____
3. Lying down to rest in the afternoon _____
4. Sitting inactive in a public place (watching movie, in a meeting) _____
5. As a passenger in a car for an hour without a break _____
6. Sitting and talking to someone _____
7. Sitting quietly after lunch without alcohol _____
8. In a car, while stopped for a few minutes in traffic _____

TOTAL (SUM OF NUMBERS ABOVE) **Total: _____**