

# ***FORT BEND HEART CENTER***



## **NEW PATIENT REGISTRATION FORM**

### ***DEMOGRAPHIC INFORMATION***

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Sex: Male  | Female  Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Marital Status: Single  | Married  | Divorced  | Separated  | Widowed  | Partner

Race: Hispanic/Latino/Spanish  | White  | Black/African American  | Asian  | Arab  |

American Indian  | Hawaiian/Pacific Island  | Other Race: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Contact: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Currently Employed? Yes  | No  | Occupation/Job Title: \_\_\_\_\_

### **☆ *ADDITIONAL INFORMATION* ☆**

Primary Care Doctor: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Reason For Today's Visit: \_\_\_\_\_

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## ***SOCIAL HISTORY***

**Tobacco Smoking Status:** Do you or have you ever smoked tobacco?

Never  | Former smoker  | Every Day Smoker  | Occasional Smoker

If yes, how many years of smoking? \_\_\_\_\_ If yes, started smoking at what age? \_\_\_\_\_

If yes, how much tobacco do you smoke? \_\_\_\_\_

Chewing Tobacco?: Never  | Former  | Every Day  | Occasional

E-cigarettes or Vape?: Never  | Former  | Every Day  | Occasional

**Alcohol Intake Status:** What is your level of alcohol consumption?

None  | Former Drinker  | Occasional  | Moderate  | Heavy

If yes, how many years have you consumed alcohol? \_\_\_\_\_

**Illicit Drug Use Status:** Do you use any illicit or recreational drugs?

Never  | Former User  | Current User

If yes, which illicit or recreational drugs have you used? \_\_\_\_\_

**Caffeine Intake Status:** What is your level of caffeine consumption?

None  | Every Day  | Occasional  | Moderate  | Heavy

What is the highest grade/level of school you have completed?: \_\_\_\_\_

Live Alone or With Others?: Alone  | With Others

Number of Children?: \_\_\_\_\_

**Diet:** Regular  | Vegetarian  | Vegan  | Gluten Free  | Carbohydrate  | Low Sodium   
| Pescatarian  | Cardiac  | Diabetic

**Exercise Level:** None  | Occasional  | Moderate  | Heavy

**Allergies:** Are you allergic to any medications? \_\_\_\_\_

## ***FAMILY HISTORY***

Is your Father: Alive  (Age \_\_\_\_ ) | Deceased  (Age \_\_\_\_ )

History of heart problems or other?: \_\_\_\_\_

Is your Mother: Alive  (Age \_\_\_\_ ) | Deceased  (Age \_\_\_\_ )

History of heart problems or other?: \_\_\_\_\_

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## ***PAST MEDICAL HISTORY***

|                                |  |  |  |
|--------------------------------|--|--|--|
| Anemia                         | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Disease                                    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Anxiety                        | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hematologic Disease                              | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Aortic Aneurysm                | Yes <input type="checkbox"/> No <input type="checkbox"/> | High Blood Pressure                              | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Arrhythmia                     | Yes <input type="checkbox"/> No <input type="checkbox"/> | High Cholesterol                                 | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Asthma                         | Yes <input type="checkbox"/> No <input type="checkbox"/> | Kidney Disease                                   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Atrial Fibrillation            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Liver Disease                                    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Atrial Flutter                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Loop Recorder                                    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Blood Clots                    | Yes <input type="checkbox"/> No <input type="checkbox"/> | Mental Illness                                   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cancer                         | Yes <input type="checkbox"/> No <input type="checkbox"/> | Neurologic Disorder                              | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cardiomyopathy                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Pacemaker  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| COPD                           | Yes <input type="checkbox"/> No <input type="checkbox"/> | Palpitations                                     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Congenital Heart Defect (CHD)  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sleep Apnea                                      | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Congestive Heart Failure (CHF) | Yes <input type="checkbox"/> No <input type="checkbox"/> | Stroke/CVA                                       | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Coronary Artery Stent          | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sexually Transmitted Disease                     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Deep Vein Thrombosis (DVT)     | Yes <input type="checkbox"/> No <input type="checkbox"/> | Syncope  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Defibrillator (ICD)            | Yes <input type="checkbox"/> No <input type="checkbox"/> | TB/Positive TB Skin Test                         | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Depression                     | Yes <input type="checkbox"/> No <input type="checkbox"/> | Thyroid Disease                                  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diabetes Mellitus              | Yes <input type="checkbox"/> No <input type="checkbox"/> | Varicose Veins                                   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| GERD/Acid Reflux               | Yes <input type="checkbox"/> No <input type="checkbox"/> | Warfarin Management                              | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Gastrointestinal Disease       | Yes <input type="checkbox"/> No <input type="checkbox"/> | <b>Other:</b> _____                              |  |
| Heart Attack                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | <b><i>NO TO ALL</i></b> <input type="checkbox"/> |  |

# FORT BEND HEART CENTER



## SURGICAL HISTORY

| SURGERY                          | DATE/YEAR PERFORMED       |
|----------------------------------|---------------------------|
| <i>Example: Cataract Surgery</i> | <i>Example: July 2022</i> |
|                                  |                           |
|                                  |                           |
|                                  |                           |
|                                  |                           |
|                                  |                           |
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|                                  |                           |
|                                  |                           |

## CARDIAC CLEARANCES

*Do you have any upcoming surgeries or procedures?*

Please select one of the following:

- I have been provided a cardiac clearance request/form. ✓
- I do not have a cardiac clearance request/form. ✘
- I do NOT plan on having any upcoming surgeries or procedures. ⊘

Name of upcoming surgery/procedure: \_\_\_\_\_

Surgeon/Doctor Name: \_\_\_\_\_

Surgeon/Doctor Phone Number: \_\_\_\_\_

My surgery is scheduled for this date: \_\_\_\_\_



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## **RELEASE OF MEDICAL INFORMATION**

*This page is intended for us to use when retrieving any medical records on your behalf to any provider.*

I hereby authorize \_\_\_\_\_ to release medical

records of: \_\_\_\_\_ from date:

\_\_\_\_\_ to \_\_\_\_\_.

These records are to be released to FORT BEND HEART CENTER.

FORT BEND HEART CENTER  
13020 Dairy Ashford Rd. Ste. 100  
Sugar Land, Tx 77478  
Phone: 281-265-8500 Fax: 281-265-8588

I hereby release you, your physician and employees from all liability for following this request.

\_\_\_\_\_

PATIENT SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

DATE

\_\_\_\_\_

WITNESS

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

DATE

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## **HIPAA**

**DR. NAIM AL-ADLI, MD, FACC, FSCAI**

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

### **OUR PLEDGE REGARDING MEDICAL INFORMATION:**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements.

### **OUR LEGAL DUTY:**

Law requires us to:

- Keep your medical information private
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information
- Follow the terms of notice that have been in effect from 4/14/2003 to present day

We have the right to:

- Change our privacy practices and terms of this notice at any time, provided that the changes are permitted by law
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes

Notice of change to privacy practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

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## **USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. **We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.**

### **FOR TREATMENT:**

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

### **FOR PAYMENT:**

We may use and disclose your medical information for payment purposes.

### **FOR HEALTH CARE OPERATIONS:**

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials we need to serve you.

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## **NOTICE OF PRIVACY PRACTICES**

### **ADDITIONAL USES AND DISCLOSURES:**

In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes.

### **DISASTER RELIEF:**

Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

### **FUNERAL DIRECTOR, CORONER, AND MEDICAL EXAMINER:**

To help them carry out their duties, we may share medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

### **COURT ORDERS AND JUDICIAL AND ADMINISTRATIVE PROCEEDINGS:**

We may disclose medical information in response to court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

### **PUBLIC HEALTH ACTIVITIES:**

As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose medical information to persons subject to jurisdiction of the Food and Drug Administration (FDA) for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacement, to track products, or to conduct activities required by the Food and Drug Administration (FDA). We may also, when we are authorized by law to

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do so, notify a person who may have been exposed to communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

## **VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE:**

We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

## **PRIVACY PRACTICE ACKNOWLEDGMENT**

**FORT BEND HEART CENTER**

**13020 Dairy Ashford. Ste. 100**

**Sugar Land, Texas 77478**

I HAVE BEEN PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICE AND HAVE  
READ AND REVIEWED IT.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE

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## **CANCELLATION OF APPOINTMENTS / NO SHOW POLICY**

### **CANCELLATION / NO SHOW POLICY FOR OFFICE VISITS:**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family matters. However; when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you in for a visit due to a seemingly full schedule.

- ★ *If an appointment is not canceled at least 24 hours in advance you will be charged a twenty-five dollar (\$25.00) fee to your account.  
Your insurance company will not cover this.*

### **TARDY POLICY FOR OFFICE VISIT:**

We understand that delays can happen however we must try to keep the other patients and doctor on time.

- ★ *If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.*

### **CANCELLATION / NO SHOW POLICY FOR PROCEDURES:**

Due to the large block of time needed for a procedure and limited number of slots available by the tech; last minute cancellations can cause problems and added expenses to the office.

- ★ *If a procedure is not canceled at least 24 hours in advance you will be charged a seventy-five dollar (\$75.00) fee to your account.  
Your insurance company will not cover this.*

*Please sign below indicating you have read and understood the cancellation policies.*

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE

# ***FORT BEND HEART CENTER***



## **PATIENT RESPONSIBILITY**

I understand and agree that I am financially responsible for all charges of any and all services rendered. This includes any medical service or visit, routine, examination, refraction, testing, Holter monitors, and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements, or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full. If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID & my Secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations, and/or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior consent. LLCEA/PS provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE

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## **INFORMATION AND ASSIGNMENT OF COVERAGE BENEFITS**

I \_\_\_\_\_ authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in place of the original.

I hereby authorize Dr. Naim Al-Adli to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance company be made directly to Dr. Naim Al-Adli or the party who accepts assignments.

I certify that the information I have reported regarding my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE