HEART POINT

PATIENT INFORMATION:			
Last Name:		First Name:	
Date of Birth: / /		Gender : MALE / FEMALE	
Last 4 SS:		Occupation:	
Address:			
Apt:	City:	State:	Zip:
Primary Phone Number:			
Secondary Phone Number:			
Email:			
EMERGENCY CONTACT:			
Emergency contact Name:			
Phone Number:			
PRIMARY CARE PHYSICIAN:			
Primary care physician's Name:			
Phone Number:		Fax Number:	
INSURANCE INFORMATION:			
Primary Insurance Name:			
Member ID:			
Secondary Insurance Name:			
Member ID:			
Who referred you to our cardiology Practice?			
Previous Cardiologist Name:			
Pharmacy name & Address:			

MEDICAL HISTORY: Please check all that apply

	High blood pressure		High Cholesterol
	Coronary artery Disease		Heart attack
	Heart Failure		Heart Murmur
	Atrial Fibrillation		Other Arrhythmia
	Heart Valve Disease		Peripheral Artery Disease
	Blood Clot/ DVT		Stroke/TIA
	Diabetes		Kidney Disease
	Thyroid Disease		Sleep Apnea
	Asthma		COPD
	Cancer		Anemia

SURGERIES & CARDIAC PROCEDURES: Have you had any of the following? If so, please add the date

	Coronary Angiogram		Coronary Stent
	Bypass Surgery		Pacemaker
	Defibrillator		Loop Recorder
	Heart Valve Surgery		Cardiac Ablation
	Cardioversion		Echocardiogram
	Stress test		Nuclear Stress Test
	Calcium score		CTA Coronary

Smoking History

Do you currently Smoke?	YES / NO
How many Cigarettes per day?	
Are you a former smoker?	YES / NO
If so, when did you quit?	

ADVANCE DIRECTIVE

Do you have an advanced directive or living will?

☐ Yes ☐ No

Do you have a healthcare power of attorney?

☐ Yes ☐ No

If yes, please provide a copy to our office if requested.

ALLERGIES: Please list any known allergies below	
Allergies to Shellfish ? YES / NO	
Allergies to Iodine? YES / NO	

MEDICATIONS: Please list all medications including the Over-the-counter medications.		
MEDICATION	DOSE	FREQUENCY

FAMILY HISTORY:		
	Medical History	Which Family Member?
	Hypertension	
	Diabetes	
	Heart Attack	
	Coronary Artery Disease	
	Bypass	
	Coronary Stents	
	Stroke/ TIA	
	High Cholesterol	
	Kidney Disease	
	Blood Clots	
	Arrythmias / SVT/ PVCs	
	Atrial Fibrillation	
	Cancer	

	Pacemaker	

CONSENT FOR TREATMENT

I hereby consent to receive medical care and treatment from **Heart Point/ Dr. Muhammad Chaudhry**. I understand that my care may include medical evaluation, diagnosis, monitoring, treatment, and follow-up services as deemed appropriate by my healthcare provider.

I understand that my physician will discuss my condition, recommended treatment options, and any significant risks or benefits with me as appropriate. I understand that I have the opportunity to ask questions and discuss any concerns regarding my care.

I understand that no specific outcome or result of treatment can be guaranteed. I also understand that I may decline or discontinue treatment, subject to applicable laws and medical considerations, after discussing my decision with my healthcare provider.

By signing below, I acknowledge that I have read and understand this Consent for Treatment and voluntarily consent to receive medical care from **Heart Point/Dr. Muhammad Chaudhry**.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

PRIVACY ACKNOWLEDGMENT

I understand that electronic communications, including text messages and email, may involve certain privacy and security risks. I understand that the practice will make reasonable efforts to protect my health information when communicating electronically.

I understand that I should notify the practice if my telephone number, mobile number, or email address changes.

I understand that electronic communications are **not intended for emergencies or urgent medical conditions**. If I am experiencing a medical emergency, I will call **911 or seek care at the nearest emergency department**.

I understand that I may withdraw or change my consent for electronic communications by notifying the practice in writing or through another method accepted by the practice. Withdrawal of consent will not affect communications that were already sent before the practice received my request.

By signing below, I confirm that I have read and understand this consent and voluntarily authorize **Heart Point staff** to communicate with me using the methods I have selected above.

PATIENT'S SIGNATURE: _____ DATE; _____

HEART POINT OFFICE POLICIES:

Please review and acknowledge the following office policies:

1. **Appointments:** Please arrive 15 minutes before your scheduled appointment. Late arrivals may need to be rescheduled.
2. **Cancellations:** Please provide at least 24 hours' notice when canceling or rescheduling an appointment. Missed appointments or late cancellations may be subject to a fee.
3. **Insurance & Payment:** Patients are responsible for providing current insurance information and for all applicable copays, deductibles, coinsurance, and balances not covered by insurance.
4. **Medications:** Please provide an accurate list of all medications, vitamins, and supplements. Do not stop or change medications without discussing it with your healthcare provider.
5. **Refills:** Prescription refill requests should be submitted during regular office hours and may require physician approval.
6. **Medical Records:** Patients may request copies or transfer of their medical records in accordance with applicable laws and office procedures.
7. **Communication:** The office may contact patients by phone, text, email, or patient portal regarding appointments, test results, medications, follow-up care, and other healthcare-related matters, consistent with the patient's communication preferences.
8. **Emergencies:** Our office is not an emergency department. For chest pain, severe shortness of breath, fainting, stroke symptoms, or another medical emergency, call **911 or go to the nearest emergency department**.
9. **Patient Responsibility:** Patients are responsible for providing accurate medical information, keeping appointments, following treatment instructions, and notifying the office of changes to their contact, insurance, medication, or medical information.
10. The patient or responsible party is ultimately responsible for charges associated with services provided, including amounts not covered by insurance. If an insurance company denies a claim or determines that a service is not covered, the patient may be responsible for the applicable balance.
    Questions regarding billing should be directed to our billing department.

I have read and understand the above office policies and agree to follow them.

Patient Signature: _____ Date: _____

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

I authorize **Heart Point Cardiology and Dr. Muhammad Chaudhry**, including authorized members of the healthcare team, to discuss information related to my medical care with the individuals listed below.

This may include, as applicable, my medical history, diagnoses, medications, laboratory results, imaging, test results, treatment plans, appointments, referrals, and other information related to my healthcare, as permitted by applicable law.

AUTHORIZED FAMILY MEMBER / FRIEND

Name: _____

Relationship: _____

Phone Number: _____

AUTHORIZED PHYSICIAN

Name: _____

Phone Number: _____

I understand that I am authorizing the individuals listed above to receive and discuss information regarding my healthcare.

I understand that I may revoke or change this authorization by notifying the practice in writing, subject to applicable law. Revocation will not affect information that has already been disclosed based on this authorization.

I understand that this authorization does not replace any separate authorization that may be required by law for certain types of protected health information.

Patient Name (Print): _____

Patient Signature: _____

Date: _____