



REGISTRATION FORM

Today's Date: _____ Social Security Number (optional): _____

First Name: _____ Middle Name: _____ Last Name: _____ Preferred Name: _____

Date of Birth: _____

Sex: Female Male

Address: _____ City: _____ State: _____ Zip: _____

Please select below the "Preferred" phone number you would like to receive call reminders, text reminders, or leave detailed messages on:

Home Phone: (____) _____ Preferred

Cell Phone: (____) _____ Preferred

Work Phone: (____) _____ Preferred

Email (To be signed up for a patient portal): _____

Contact Preference: Email Fax Letter Phone

Emergency Contact: _____ Relation to Patient: _____

Emergency Contact's Primary Phone: (____) _____ Alt. Phone: (____) _____

Referring MD: _____ Primary Care Physician: _____ Prior Cardiologist: _____

Reason for visit today: _____

Language: English Other _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Other _____

Race: American Native Alaska Native Asian Asian Indian African American

Black Japanese Native Hawaiian or Other Pacific Islander

White Other _____

Affinity Heart Care, P.A.

Farhana Kazi, M.D.

Notice of Privacy Practices

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

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. We may also provide your physician and other specialists with information about your particular condition so that they can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, your health plan may request and receive information on dates of service, the services provided, and medical condition being treated.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigation, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders via telephone, email and text.

Information about treatments. We may send you information describing health-related information that we believe may interest you. You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information. The right to receive confidential communications concerning your medical condition and treatment. The right to inspect and copy your protected health information. The right to amend or submit corrections to your protected health information. The right to receive an accounting of how and to whom your protected health information has been disclosed. The right to receive a printed copy of this notice.

Practice Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our policies and practices. These changes may be required by due to federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit and will be applied to all protected health information we maintain.

Requests to inspect Protected Health Information

You may inspect or copy the protected health information (PHI) that we maintain. As permitted by federal regulation, we require that requests to inspect or copy PHI be submitted in writing. You may request access to your records by contacting the office. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copies.

Complaints

If you would like to submit a comment or complaint about our practices, please let us know. If you believe that your privacy rights have been violated, please call the matter to our attention by sending a letter describing the cause of your concern. You will not be penalized or retaliated against for filing a complaint. You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

I have reviewed this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

Printed Name of Patient

Date of Birth

Signature of Patient or Responsible Party

Current Date

Affinity Heart Care, P.A.

Farhana Kazi, M.D.

Authorization to Release Healthcare Information – Provider:

Affinity Heart Care
Farhana Kazi, MD
215 S. Denton Tap Road Suite 225 Coppell, Texas 75019
Phone: (469) 293-2067 Fax: (469) 293-2083

This is a release form for authorization of your medical information to be transferred between health care providers, health insurance companies, and any other party involved in your medical care.

Patient Name: _____ **Date of Birth:** _____

I authorize the following facilities/hospitals, and doctor(s) to release all medical information to Affinity Heart Care, PA to better manage my health.

This request includes: hospital summaries, echocardiogram reports, cardiac catheterization reports, laboratory reports, electrocardiograms, physician progress notes, and any other healthcare information relating to my condition.

List facility name(s), hospital name(s) and/or physician(s) below where you have been seen so that we may obtain your medical information:

1 _____

2 _____

3 _____

Signature of Patient or Responsible Party

Current Date

Authorization to Release Healthcare Information – Individual:

I hereby authorize the following person (s) to be involved with and receive information pertaining to my medical care. I understand that any and all information can only be given in person, and after presenting a picture ID:

Name	Relationship

Printed Name of Patient

Date of Birth

Signature of Patient or Responsible Party

Current Date

Affinity Heart Care, P.A.

Farhana Kazi, M.D.

ROOM: _____

Confidential Health Questionnaire

Current Date:	Patient Name:
----------------------	----------------------

Visit Reason:	Date of Birth:	Age:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
----------------------	-----------------------	-------------	---

Vitals (to be filled out by MA):

Has patient taken meds already? Yes: No: If so: How long ago? _____

MRN:	BP: _____ / _____ RA / LA _____ / _____ RA / LA	SpO2:	HR: _____ BPM	Ht:	Wt:
-------------	---	--------------	-----------------------------	------------	------------

List any medical problems that other doctors have diagnosed you with

<input type="checkbox"/> Allergies	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Sleep Disorder
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Hematologic Disease	<input type="checkbox"/> CPAP/APAP Therapy
<input type="checkbox"/> Aortic Aneurysm	<input type="checkbox"/> Carotid Disease	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> Abdominal Aortic Aneurysm	<input type="checkbox"/> Congestive Heart Failure (CHF)	<input type="checkbox"/> Hypertension	<input type="checkbox"/> TIA
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Deep Vein Thrombosis	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Valvular Abnormalities
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Migraines	<input type="checkbox"/> Valvular Heart Disease
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Myocardial Infarction	<input type="checkbox"/> Warfarin/Coumadin
<input type="checkbox"/> Atrial Flutter	<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> Neurologic Disorder	Other: _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Pacemaker	Other: _____
<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Gastrointestinal Disease	<input type="checkbox"/> Peripheral Arterial Disease	Other: _____
<input type="checkbox"/> COPD	<input type="checkbox"/> Genitourinary Disease	<input type="checkbox"/> Sleep Apnea	Other: _____

Have you been hospitalized in the last year?

Date	Reason	Hospital

Have you had any past surgeries/procedures? (Please write at least the year next to surgery)

<input type="checkbox"/> AICD	<input type="checkbox"/> Cardiac Catheterization	<input type="checkbox"/> HEENT	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Abd Aortic Aneurysm Repair	<input type="checkbox"/> Cardioversion	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Spleen
<input type="checkbox"/> Abdominal	<input type="checkbox"/> Cholecystectomy (Gallbladder)	<input type="checkbox"/> Hip	<input type="checkbox"/> Stent
<input type="checkbox"/> Angioplasty	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Stress test or Stress Echo
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Coronary Artery Stent	<input type="checkbox"/> Kidney/Bladder	<input type="checkbox"/> Stomach
<input type="checkbox"/> Back	<input type="checkbox"/> Cosmetic	<input type="checkbox"/> Knee	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Bowel	<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Lung	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Brain	<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Mohs	<input type="checkbox"/> Tonsillectomy/Adenoidectomy
<input type="checkbox"/> Breast	<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Orthopedic	<input type="checkbox"/> Vascular
<input type="checkbox"/> CABG	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Caesarean Section	<input type="checkbox"/> Heart	<input type="checkbox"/> Prostate	Other: _____
<input type="checkbox"/> Carotid Ultrasound	<input type="checkbox"/> Heart Valve	<input type="checkbox"/> Pharmacologic stress test	Other: _____

Affinity Heart Care, P.A.

Farhana Kazi, M.D.

ROOM: _____

Confidential Health Questionnaire

Patient Name: _____

List your prescribed and over-the-counter medications

Name	Strength	Frequency Taken	Name	Strength	Frequency Taken

List your preferred Pharmacy (list a secondary if primary is mail order):

Primary Pharmacy <i>(include address):</i> _____	Secondary Pharmacy: <i>(include address):</i> _____
--	---

Known Drug Allergies (or NKDA if no allergies to medications)

Medication:	Reaction:

Family History

List any family medical history such as: *high blood pressure, heart attack, heart disease, stented arteries, diabetes, stroke, diabetes, high cholesterol, arrhythmia, bypass, heart failure, kidney/thyroid disease, cancer, etc.*
(Please also circle if family member is alive or deceased. If deceased, please try to provide the age.)

Father:	Alive / Deceased : _____
Mother:	Alive / Deceased : _____
Grandfather (Paternal):	Alive / Deceased : _____
Grandmother (Paternal):	Alive / Deceased : _____
Grandfather (Maternal):	Alive / Deceased : _____
Grandmother (Maternal):	Alive / Deceased : _____
Uncle (Maternal / Paternal):	Alive / Deceased : _____
Aunt (Maternal / Paternal):	Alive / Deceased : _____
Brothers / Sisters:	Alive / Deceased : _____
Children:	Alive / Deceased : _____
Other:	Alive / Deceased : _____

Social History

Occupation: _____ Retired Unemployed Employed (full-time) Employed (part-time) Student

Marital Status: Single Partnered Married Separated Divorced Widowed

Smoke/Chew tobacco?	Never <input type="checkbox"/>	Current: Someday <input type="checkbox"/>	Former <input type="checkbox"/>	Quit <input type="checkbox"/> Date Quit: _____
	Everyday <input type="checkbox"/>			

If yes, type of tobacco and how much/day:

Cigarettes <input type="checkbox"/> packs/day:	Chew <input type="checkbox"/> #/day:	Pipe <input type="checkbox"/> #/day:	Cigars <input type="checkbox"/> #/day:
--	--------------------------------------	--------------------------------------	--

Drink alcohol? Yes No If yes, what kind, and how many drinks per day/week? _____

Do you use recreational drugs? Yes No If yes, what kind, and how often? _____

Exercise: None Occasional Moderate Heavy Type: _____

Caffeine: None Coffee Tea Cola # cups/cans per day: _____

Affinity Heart Care, P.A.

Farhana Kazi, M.D.

ROOM: _____

Confidential Health Questionnaire

Patient Name: _____

Cardiac Device: Yes <input type="checkbox"/> No <input type="checkbox"/>	Type: Pacemaker <input type="checkbox"/> or ICD <input type="checkbox"/>	Mfr: Biotronik <input type="checkbox"/> Boston Scientific <input type="checkbox"/> Medtronic <input type="checkbox"/> St Jude <input type="checkbox"/>
---	---	--

Do meet any of the following criteria:

65+ years of age <input type="checkbox"/>	Diabetics and 50+ years of age <input type="checkbox"/>	Critical limb ischemia (CLI) <input type="checkbox"/>
Smoker and 50+ years of age <input type="checkbox"/>	Abnormal pulses during exam <input type="checkbox"/>	Received a Framingham risk score of >10-20% <input type="checkbox"/>
Diabetics < 49 years of age with 1 or more risk factors (i.e. smoking, high blood pressure, stroke) <input type="checkbox"/>	Claudication in the leg or chronic leg pain <input type="checkbox"/>	Known history of Coronary Artery Disease (CAD), Renal Artery Stenosis (RAS), Carotid Endarterectomy (CEA) <input type="checkbox"/>
Witnessed apnea events during sleep greater than 10 seconds in duration <input type="checkbox"/>	Disruptive snoring <input type="checkbox"/>	Gasping / choking <input type="checkbox"/>
Excessive daytime sleepiness <input type="checkbox"/>	Awaken with headache or dry mouth <input type="checkbox"/>	Mood disorder, fatigue, inability to concentrate <input type="checkbox"/>
History of heart disease <input type="checkbox"/>	Hypertension / high blood pressure <input type="checkbox"/>	History of stroke or family history <input type="checkbox"/>
Craniofacial abnormalities <input type="checkbox"/>	Upper airway soft tissue abnormalities <input type="checkbox"/>	Non-restorative sleep <input type="checkbox"/>
Disturbed or restless sleep <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Congestive heart failure <input type="checkbox"/>
COPD / Chronic lung disease <input type="checkbox"/>	Cardiac arrhythmia <input type="checkbox"/>	Hx of AMI / Stroke (<6 months) <input type="checkbox"/>
Pulmonary hypertension <input type="checkbox"/>	Neuromuscular weakness <input type="checkbox"/>	Seizures <input type="checkbox"/>
Neurodegenerative disorder or cognitive impairment <input type="checkbox"/>	Previously diagnosed with sleep apnea <input type="checkbox"/>	Currently using CPAP/APAP <input type="checkbox"/>
Currently using supplemental oxygen <input type="checkbox"/>	Obesity hypoventilation syndrome (OHC) <input type="checkbox"/>	Other: _____

Epworth Sleepiness Scale (answer if issue with fatigue or snoring)

Choose the most appropriate response for each situation	Never would doze off 0	Slight chance of dozing 1	Moderate chance 2	High chance of dozing 3
1. Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sitting inactive in a public place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Laying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sitting and talking with someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Sitting quietly after lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Score of all questions (sum total of all eight responses): _____

Review of Systems (Check any current or recent symptoms below)				
Current Date:		Patient Name:		
Constitutional				
Fever	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	*If weight gain, how much ? _____
Fatigue	<input type="checkbox"/>	Chills	<input type="checkbox"/>	*If weight loss, how much? _____
Eyes				
Dryness	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	Pain in eyes <input type="checkbox"/>
Redness	<input type="checkbox"/>	Loss of vision	<input type="checkbox"/>	Watery eyes <input type="checkbox"/>
Ears/Nose/Throat/Mouth				
Hearing Loss	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	Bleeding gums <input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	Sinus pain	<input type="checkbox"/>	Bad taste or breath <input type="checkbox"/>
Ear ache	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	Tonsillitis <input type="checkbox"/>
Cardiovascular				
Chest pressure	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Sleep apnea <input type="checkbox"/>
Chest pain	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	Calf/buttock pain while walking <input type="checkbox"/>
Ankle/feet swelling	<input type="checkbox"/>	Arrhythmia	<input type="checkbox"/>	High BP or Chol <i>(circle)</i> <input type="checkbox"/>
Respiratory				
Cough: dry or wet <i>(circle)</i>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Sleep apnea <input type="checkbox"/>
Gastrointestinal				
Nausea vomiting <i>(circle)</i>	<input type="checkbox"/>	Blood in stool Black stool	<input type="checkbox"/>	Bloating <input type="checkbox"/>
Heartburn indigestion <i>(circle)</i>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	GERD <input type="checkbox"/>
Constipation	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Difficulty swallowing <input type="checkbox"/>
Genitourinary				
Retention of urine	<input type="checkbox"/>	Inability of emptying	<input type="checkbox"/>	Blood in urine (hematuria) <input type="checkbox"/>
Pain or Burn in urination	<input type="checkbox"/>	Urine frequency: Day / night <i>(Nocturia / Polyuria)</i>	<input type="checkbox"/>	Sexual problems <input type="checkbox"/>
Musculoskeletal				
Muscle ache or weakness	<input type="checkbox"/>	<u>Neck, back, knee, ankle, shoulder, elbow, wrist, joint pain</u> <i>(circle)</i>	<input type="checkbox"/>	Joint swelling/stiffness <i>(circle)</i> <input type="checkbox"/>
Skin/Breasts				
Rash	<input type="checkbox"/>	Dry Hair	<input type="checkbox"/>	Skin discoloration <input type="checkbox"/>
Itchy skin	<input type="checkbox"/>	Loss of hair	<input type="checkbox"/>	Skin lesion <input type="checkbox"/>
Neurological				
Migraine	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	Difficulty walking <input type="checkbox"/>
Headache	<input type="checkbox"/>	Seizures or Tremors <i>(circle)</i>	<input type="checkbox"/>	Difficulty speaking <input type="checkbox"/>
Numbness	<input type="checkbox"/>	Syncope Dizziness <i>(circle)</i>	<input type="checkbox"/>	Memory loss <input type="checkbox"/>
Psychosocial				
Anxiety	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Feeling irritable <input type="checkbox"/>
Depression	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	Mood swings <input type="checkbox"/>
Endocrine				
Sweating	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Croaky voice	<input type="checkbox"/>	Increased appetite (Polyphagia)	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymphatic				
Easy bruising	<input type="checkbox"/>	Swollen glands	<input type="checkbox"/>	Bleeding /Clotting tendency <i>(circle)</i> <input type="checkbox"/>
Allergy/Immune				
Allergic reactions	<input type="checkbox"/>	Hives	<input type="checkbox"/>	Frequent infections <input type="checkbox"/>

PAD SCREENING ASSESSMENT

Patient Name:
Age:

Current Date:
Circle: Male or Female

RISK FACTORS

- | | | | | |
|---|-----|--------------------------|----|--------------------------|
| Do you experience any pain in your legs or feet while at rest? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Do you have uncomfortable aching, fatigue, tingling, cramping, or pain in your feet, calves, buttocks, hip or thigh during walking/exercise? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| ^If yes, does the pain go away when you stop walking/exercising? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Do your feet get pale, discolored, or bluish at any time during the day? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Do you have an infection, skin wound or ulcer on your leg or foot that is slow or heal over the past 8-12 weeks? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Do you have high blood pressure or take medication to reduce blood pressure? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Do you have diabetes? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Do you have history of chronic kidney disease? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Do you currently or have you ever smoked? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Do you have a history of stroke or mini-stroke (TIA)? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Do you have a history of heart disease (heart attack)? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Do you have a history of carotid stenosis, AAA (abdominal aortic aneurysm), and/or stent placement? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

ADDITIONAL COMMENTS