Affinity Heart Care, P.A.

Farhana Kazi, M.D.

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:**_____

Home Phone:(_____**)**_____ ☐ **Preferred**

Cell Phone: (____**)** _____ ☐ **Preferred**

Work Phone: (_____**)** _____ ☐ **Preferred**

Email (For 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** _____

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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

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Confidential Health Questionnaire

Current Date:	**Patient Name:**		
Visit Reason:	**Date of Birth:**	**Age:**	**Sex: M ☐ F ☐**

Vitals (to be filled out by MA):
Has patient taken meds already? Yes: ☐ No: ☐ If so: How long ago? _____

PID:	BP: _____ / _____ RA / LA _____ / _____ RA / LA	SpO2: ___ ___	HR: _____ BPM _____	Ht:	Wt:

List any medical problems that other doctors have diagnosed you with

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

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

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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:		**Secondary Pharmacy:**	

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.**

Father:

Mother:

Grandfather (Paternal):

Grandmother (Paternal):

Grandfather (Maternal):

Grandmother (Maternal):

Uncle (Maternal / Paternal):

Aunt (Maternal / Paternal):

Brothers / Sisters:

Children:

Other:

Social History

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

Marital Status: Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Smoke/Chew tobacco?	Never ☐	Current: Someday ☐ Everyday ☐	Former ☐	Quit ☐ Date Quit:

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

Cigarettes ☐ packs/day:	Chew ☐ #/day:	Pipe ☐ #/day:	Cigars ☐ #/day:

Drink alcohol? Yes ☐ No ☐	If yes, how many drinks per day/week?

Do you use recreational drugs? Yes ☐ No ☐

Exercise: None ☐ Occasional ☐ Moderate ☐ Heavy ☐ Type:

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

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Confidential Health Questionnaire

Patient Name:

Cardiac Device: Yes ☐ No ☐	**Type:** Pacemaker ☐ or ICD ☐	**Mfr:** Biotronik ☐ Boston Scientific ☐ Medtronic ☐ St Jude ☐

Do meet any of the following criteria:

65+ years of age ☐	Diabetics and 50+ years of age ☐	Critical limb ischemia (CLI) ☐
Smoker and 50+ years of age ☐	Abnormal pulses during exam ☐	Received a Framingham risk score of >10-20% ☐
Diabetics < 49 years of age with 1 or more risk factors (i.e. smoking, high blood pressure, stroke) ☐	Claudication in the leg or chronic leg pain ☐	Known history of Coronary Artery Disease (CAD), Renal Artery Stenosis (RAS), Carotid Endarterectomy (CEA) ☐
Witnessed apnea events during sleep greater than 10 seconds in duration ☐	Disruptive snoring ☐	Gasping / choking ☐
Excessive daytime sleepiness ☐	Awaken with headache or dry mouth ☐	Mood disorder, fatigue, inability to concentrate ☐
History of heart disease ☐	Hypertension / high blood pressure ☐	History of stroke or family history ☐
Craniofacial abnormalities ☐	Upper airway soft tissue abnormalities ☐	Non-restorative sleep ☐
Disturbed or restless sleep ☐	Diabetes ☐	Congestive heart failure ☐
COPD / Chronic lung disease ☐	Cardiac arrhythmia ☐	Hx of AMI / Stroke (<6 months) ☐
Pulmonary hypertension ☐	Neuromuscular weakness ☐	Seizures ☐
Neurodegenerative disorder or cognitive impairment ☐	Previously diagnosed with sleep apnea ☐	Currently using CPAP/APAP ☐
Currently using supplemental oxygen ☐	Obesity hypoventilation syndrome (OHC) ☐	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	☐	☐	☐	☐
2. Watching TV	☐	☐	☐	☐
3. Sitting inactive in a public place	☐	☐	☐	☐
4. As a passenger in a car for an hour without a break	☐	☐	☐	☐
5. Laying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
6. Sitting and talking with someone	☐	☐	☐	☐
7. Sitting quietly after lunch without alcohol	☐	☐	☐	☐
8. In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

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

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

215 S. Denton Tap Rd, Ste 225
Coppell, TX 75019
Telephone: 469-293-2067
Fax: 469-293-2083
www.affinityheartcare.com

VEIN SCREENING ASSESSMENT

Patient Name: **Current Date:**

PAST HISTORY

Have you ever had varicose veins or bulging veins?	Yes	☐	No	☐

SIGNS AND SYMPTOMS

Do you experience <u>ANY</u> of the following in your legs or ankles?

- Leg pain, aching or cramping ☐
- Burning or itching of the skin ☐
- Leg or ankle swelling, especially at the end of the day ☐
- "Heavy" feeling in legs ☐
- Varicose veins ☐
- Skin discoloration or texture changes, such as above the inner ankle ☐
- Restless legs ☐

RISK FACTORS

Has anyone in your family ever had varicose veins?	Yes	☐	No	☐
Have you had any treatments or procedures for vein problems?	Yes	☐	No	☐
Do you sit or stand for long periods of time, such as at work?	Yes	☐	No	☐
Do you frequently engage in heavy lifting?	Yes	☐	No	☐

ADDITIONAL COMMENTS