New Patient's Information Sheet

Patient Information

Name (First): _____ (M.I): _____ (Last): _____

Date of Birth: _____ Age: _____ Sex: M F Social Security #: _____

Marital Status: Married Single Widowed Divorced

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

Phone Numbers: Home: _____ Cell: _____ Work: _____

Employed? Y / N Employer: _____

Email Address (for appointment reminder): _____

Responsible Party or Spouse Information

Name (first): _____ Relationship to Patient: _____

Address: _____

Phone: _____ Cell: _____ Alt #: _____

Social Security #: _____ Driver's License #: _____

Employer: _____

Employer Address: _____

Insurance Information

Insurance Company: _____ Phone #: _____

Member ID#: _____ Group #: _____

Address: _____

Insured Name: _____ Relationship to patient: _____

I hereby assign, transfer, and set for to Uttam Tripathy, M.D. all of my right, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance.

Patient's Signature: _____ **Date:** _____

Uttam Tripathy, M.D.
Cardiovascular and Thoracic Surgery
281.232.1908
281.232.1914 (Fax)

Date: _____

MEDICAL QUESTIONNAIRE

PLEASE COMPLETE THE FOLLOWING QUESTIONS. THIS WILL MAKE YOUR VISIT GO FASTER AND HELP US TAKE BETTER CARE OF YOU.

Name: _____ DOB: _____ Age: _____

(Please circle one) Single Married Divorced Widowed

Phone Numbers: (Home) _____ (Mobile) _____

PHYSICIAN INFORMATION

Referring Physician: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Cardiologist: _____ Phone Number: _____

Other Health Providers: _____

Pharmacy and Telephone #: _____

MAIN REASON FOR YOUR VISIT TODAY:

_____

_____

_____

PHYSICIAN NOTES (HISTORY):

Name: _____ DOB: _____ Date: _____

MEDICAL HISTORY: *If you are being treated or have you ever been treated for any of the following problems, please check:*

- O DIABETES
- O HIGH BLOOD PRESSURE
- O HEART DISEASE
- O HIGH CHOLESTEROL
- O HEART FAILURE
- O CIRCULATION PROBLEMS WITH YOUR LEGS
- O STROKES
- O HISTORY OF BLOOD CLOTS
- O VARICOSE VEINS
- O KIDNEY PROBLEMS
- O CANCER
- O LUNG PROBLEMS
- O LIVER PROBLEMS
- O HEPATITIS
- O HIV OR AIDS

If there are any other health problems that you are being treated for or have been treated for, please list them.

_____

_____

SURGICAL HISTORY: *Please list previous surgical procedures:*

[illegible]	[illegible]

MEDICATIONS: *Please list all medications & dosage you are presently taking and how often you take them*

[illegible]	[illegible]	[illegible]

Name: _____ DOB: _____ Date: _____

ALLERGIES: *Please list all known allergies and the reaction they caused:*

_____

_____

Are you allergic to the following?

Penicillin	YES	NO
Iodine	YES	NO
Shellfish (like shrimp)	YES	NO
Contrast or IV Dye	YES	NO
Latex	YES	NO
Local Anesthetic	YES	NO

SOCIAL HISTORY

Do you have any social/ cultural/ religious preferences that may affect your medical care? YES NO

If so, please specify: _____

_____

Smoking History

Do you smoke? YES NO If so, how much? _____

Have you smoked in the past? (Please circle one) YES NO When did you quit? _____

Do you drink alcoholic beverages? (Please circle one) YES NO

If so, how much alcohol do you drink? _____

Do you work? (Please circle one) YES NO

If so, what sort of work do you do? _____

FAMILY HISTORY: *If anyone in your family has these diseases, please check:*

- O DIABETES
- O HIGH BLOOD PRESSURE
- O KIDNEY FAILURE
- O HEART DISEASE
- O STROKES
- O CANCER
- O PERIPHERAL VASCULAR DISEASE
- O VARICOSE VEINS
- O BLOOD CLOTTING OR BLEEDING PROBLEMS
- O HISTORY OF ANEURYSMS

NAME: DOB: DATE:

Review of Systems (Please check YES or NO for the following problems & conditions):

		YES	NO
General:	Nausea/Vomiting?		
	Fever/Chills?		
	Weight loss or gain? Please specify:		
Skin:	Rashes?		
	Skin color changes?		
HEENT:	Frequent or unusual headaches?		
	Recent changes in vision?		
	Persistent Cough?		
	Hearing Loss?		
Cardiac:	Chest Pain		
	Angioplasty or Stents for the heart?		
	Palpitations (feeling your heart is beating irregularly)?		
	Recent EKG?		
	Recent Stress Test?		
Respiratory:	Shortness of breath?		
	Can you walk up a flight of stairs without stopping?		
Vascular:	Circulation problems in the legs?		
	Pain in your legs when you walk?		
	Angioplasty or bypass surgery for the legs?		
	Foot wounds that would not heal?		
	Leg swelling?		
	Varicose veins?		
Neurologic:	Strokes?		
	Weakness or numbness on one side of the body?		
	Seizures?		
	Dizziness/Fainting spells?		
	Loss of vision?		
GI:	Abdominal pain?		
	Acid Reflux?		
	Stomach ulcers?		
	Stomach pain with eating?		
	Change in bowel movements?		
Musculoskeletal:	Back Pain?		
	Painful joints?		
Psychiatric:	Depression or changes in mood?		
	Anxiety?		
Heme/Onc:	History of Cancer?		
	Bleeding/Clotting disorders?		

The above ROS were reviewed with patient. **Physician Initials** _____.

HIPAA 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.

We may use or share your medical information without your permission for the reasons below:

- So you can get medical care. For example, we may share your medical information with your doctors or pharmacies so that they can provide you with appropriate medical care.
- So we can perform our duties. For example: to assess quality of care; to manage your care; or for audits.
- To inform you about other health services.
- To comply with the law.
- For other reasons:
    - To comply with legal proceedings, such as a court or administrative order or subpoena;
    - To enforce other laws or protect someone's health and safety;
    - So a family member, friend or other person can help you to get or pay for your health care;
    - So a personal representative you appoint or a court appoints for you can help you get health benefits;
    - To support research as long as the information will be protected by the researchers;
    - So a coroner or medical examiner can identify a deceased person or cause of death or so a funeral director can arrange burial;
    - To support an organ procurement organization in limited circumstances;
    - To protect you against a serious threat to your health or safety or the health or safety of others;
    - To support a government agency overseeing health care programs;
    - For lawful national security purposes;
    - For public health purposes and for military purposes, if you are a member of the armed forces.

We will not use or share your medical information for any other reason unless you give us written permission. You may withdraw your permission in writing at any time. Your permission for us to use or share your information will end when we get your written notice withdrawing your permission.

Your rights. You may ask us in writing to do any of the following. We will decide if it can be done based on the Privacy Protection Standards outlined in HIPAA.

- You may ask us not to use or share your medical information.
- You may ask we contact you about your medical information privately in a different way or at a different place than we are currently doing.
- You may ask to see or obtain copies of your medical information. You may be charged a fee for copies.
- You may ask us to correct your medical information.
- You may ask for a list of ways we shared your medical information for up to 6 years. We can provide you with information shared on or after April 14, 2003.

Complaints. If you believe we have not protected your right to privacy, you have the right to complain to us or the Secretary of the U.S. Department of Health and Human Services.

We reserve the right to change our privacy practices. If you have any questions, contact us at 281-232-1908.

I understand and accept the terms of these practices:

Signature: _____ Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

* _____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name UTAM TRIPATHY, MD
Address 16605 SOUTHWEST FRWY #575 MOB 3
City SUGAR LAND State TX Zip Code 77479
Phone (281) 232-1908 Fax (281) 232-1914

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

* **SIGNATURE X** _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual **DATE**

Uttam Tripathy, M.D.
Cardiovascular and Thoracic Surgery
Tel 281.232.1908 **Fax** 281.232.1914

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH AND PATIENT ACCESS

1. I authorize Uttam Tripathy, M.D. to disclose

information from the health records of: _____
(patient)

SSN# _____ Date of Birth: _____

2. **The information is to be disclosed to:** _____

Address: _____

City, State, Zip: _____

Contact Person: _____

Phone/Fax: _____

I authorize this information to be disclosed in the following ways:

❑ Written/Photocopy/Paper ❑ Verbal ❑ Fax ❑ Electronic Mail *

Purpose of the disclosure: _____

3. **Dates of Treatment:** From: _____ To: _____

Specific reports to be disclosed:

❑ Progress Notes ❑ Laboratory Reports ❑ Operative Reports
❑ Discharge Summary ❑ Radiology Reports ❑ Consultation Reports
❑ X-ray films or other images ❑ Photographs/Videotapes ❑ Records from other facilities
❑ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
❑ Other(Specify): _____

I give specific authorization to disclose the following information:

❑ HIV test results ❑ Documentation of AIDS diagnosis
❑ Drug and alcohol abuse treatment records ❑ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Cardiovascular & Thoracic Surgery, Dr. Uttam Tripathy in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient (Relationship to Patient)