



# New Patient Form (Dr. Villa) Palm Beach Cardiovascular Clinic

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Chief complaint:**

\_\_\_\_\_  
\_\_\_\_\_

	Yes	No	Type and frequency
Do you Exercise?			

**Have you experienced:**

	Yes	No	When	Hospitalized?
Chest pain / discomfort				
Shortness of breath				
Palpitations				
Dizziness / Lightheadedness				
Fatigue / Tiredness				

	Yes	No	When	Hospitalized?
Edema (Swelling)				
Leg Pain				
Varicose Veins				
_____				
_____				

**Illnesses:**

	Yes	No	Year	Hospitalized?
Heart Attack				
Stroke				
Congestive Heart Failure				
SYNCOPE (Blackout)				

	Yes	No	Year	Hospitalized?
ARRHYTHMIAS (Irregular Rhythm)				
Heart Murmur				
_____				
_____				

**Coronary artery disease risk factors:**

	Yes	No	Year
Hypertension			
Diabetes Mellitus			

	Yes	No	Year
High Cholesterol			
Smoking			Amounts: _____ Years: _____

**Past medical History:**

	Yes	No	Year	Hospitalized?
Emphysema				
Asthma				
Peptic ulcer disease				
GI bleeding				
Gastroesophageal Reflux				
Kidney disorders				

	Yes	No	Year	Hospitalized?
Liver disorders				
Thyroid gland disorders				
Cancer				
Hepatitis				
_____				
_____				

**Reviewed by Dr. Villa:** \_\_\_\_\_

# New Patient Form (Dr. Villa)

**Operations:** (Year)

Hospital

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies:**

Question	Yes	No	Type of Reaction
Are you allergic to any IODINE?			
Are you allergic to any Shell Fish?			
Are you allergic to any Medicine?			

**If yes please list Medicines**

- 1) \_\_\_\_\_
- 4) \_\_\_\_\_
- 7) \_\_\_\_\_
- 2) \_\_\_\_\_
- 5) \_\_\_\_\_
- 8) \_\_\_\_\_
- 3) \_\_\_\_\_
- 6) \_\_\_\_\_
- 9) \_\_\_\_\_

**CARDIAC family history:**

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

Grandparents: \_\_\_\_\_

**Medications/Supplements (Doses):**

- 1) \_\_\_\_\_
- 6) \_\_\_\_\_
- 2) \_\_\_\_\_
- 7) \_\_\_\_\_
- 3) \_\_\_\_\_
- 8) \_\_\_\_\_
- 4) \_\_\_\_\_
- 9) \_\_\_\_\_
- 5) \_\_\_\_\_
- 10) \_\_\_\_\_

**Social History:**

Marital Status: \_\_\_\_\_ Children: \_\_\_\_\_

Profession: \_\_\_\_\_ Coffee: \_\_\_\_\_

Alcohol: \_\_\_\_\_ Recreational Drugs: \_\_\_\_\_

Comments: \_\_\_\_\_

**Reviewed by Dr. Villa:**

\_\_\_\_\_

**Review of Systems (Check only the ones you have or have had recently)**

<p><b>Yes General</b></p> <input type="checkbox"/> Weakness <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fainting	<p><b>Yes Mouth</b></p> <input type="checkbox"/> Bleeding Mouth <input type="checkbox"/> Ulcers <input type="checkbox"/> Dental problems <input type="checkbox"/> Mouth Pain <input type="checkbox"/> Bad Breath <input type="checkbox"/> Loss of Taste	<p><b>Yes Blood</b></p> <input type="checkbox"/> Anemia <input type="checkbox"/> Bruising <input type="checkbox"/> Prolonged <input type="checkbox"/> Bleeding <input type="checkbox"/> Swollen Nodes <input type="checkbox"/> Red Dots/Spots <input type="checkbox"/> Blood Clots	<p><b>Yes Psychiatric</b></p> <input type="checkbox"/> Hyper-ventilation <input type="checkbox"/> Insecurity <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Irritability <input type="checkbox"/> Anxiousness / Stress <input type="checkbox"/> Indecisiveness <input type="checkbox"/> Timid / Shy / Bashful <input type="checkbox"/> Hallucinations <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Worrying <input type="checkbox"/> Obsessive <input type="checkbox"/> Panic Attacks	<p><b>Yes Gastro-Intestinal</b></p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Belching <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Irreg. Bowel Movements <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernias <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Food Intolerance <input type="checkbox"/> Bloody Stool <input type="checkbox"/> Black Tarry Stools <input type="checkbox"/> Excessive Appetite
<p><b>Yes Eyes</b></p> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Redness <input type="checkbox"/> Itching <input type="checkbox"/> Burning <input type="checkbox"/> Swelling <input type="checkbox"/> Pain <input type="checkbox"/> Dryness <input type="checkbox"/> Tearing	<p><b>Yes Nose</b></p> <input type="checkbox"/> Decreased Smell <input type="checkbox"/> Bleeding <input type="checkbox"/> Pain <input type="checkbox"/> Discharge <input type="checkbox"/> Obstruction <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Runny Nose <input type="checkbox"/> Sinus Congestion	<p><b>Yes Genitourinary</b></p> <input type="checkbox"/> Urgency <input type="checkbox"/> Incontinence <input type="checkbox"/> Straining <input type="checkbox"/> Flank Pain <input type="checkbox"/> Stones <input type="checkbox"/> Burning <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Small Stream <input type="checkbox"/> Urethral <input type="checkbox"/> Discharge <input type="checkbox"/> Dripping <input type="checkbox"/> Cloudy Urine <input type="checkbox"/> Unusual Color <input type="checkbox"/> Urination at Night <input type="checkbox"/> Hesitancy	<p><b>Yes Neurological</b></p> <input type="checkbox"/> Seizures <input type="checkbox"/> Vertigo <input type="checkbox"/> Sensation Loss <input type="checkbox"/> Trembling Hands <input type="checkbox"/> Uncoordinated <input type="checkbox"/> Expression loss <input type="checkbox"/> Weak Grip <input type="checkbox"/> Paralysis <input type="checkbox"/> Slurred Speech <input type="checkbox"/> Memory loss <input type="checkbox"/> Disorientation <input type="checkbox"/> Gait Shuffling <input type="checkbox"/> No Concentration	
<p><b>Yes Ears</b></p> <input type="checkbox"/> Hearing difficulty <input type="checkbox"/> Deafness <input type="checkbox"/> Discharge <input type="checkbox"/> Ringing <input type="checkbox"/> Earache <input type="checkbox"/> Itching <input type="checkbox"/> Dizziness	<p><b>Yes Lungs</b></p> <input type="checkbox"/> Mucous <input type="checkbox"/> Coughing blood <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest Congestion			
<p><b>Yes Head</b></p> <input type="checkbox"/> Headaches <input type="checkbox"/> Injuries <input type="checkbox"/> Bumps				

**Reviewed by**

**Dr. Villa:** \_\_\_\_\_

**Palm Beach Cardiovascular Clinic**

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ WORK #: \_\_\_\_\_ CELL #: \_\_\_\_\_  
REFERRING PHYSICIAN: \_\_\_\_\_ REFERRING DR PHONE: \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_

**EMERGENCY CONTACT:**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

**INSURANCE INFORMATION**

**~~ PLEASE HAVE YOUR INSURANCE CARDS READY FOR PHOTOCOPYING ~~**

PRIMARY INS: \_\_\_\_\_ NAME OF INSURED: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SECONDARY INS: \_\_\_\_\_ NAME OF INSURED: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

**\*\*\*\* IF YOUR INSURANCE REQUIRES A REFERRAL FOR YOU TO SEE Dr. Villa, IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE REFERRAL. IF YOUR INSURANCE COMPANY DENIES PAYMENT – DUE TO NO REFERRAL – YOU THE PATIENT AGREES TO PAY Dr. Villa IN FULL FOR ANY CHARGES INCURRED DURING YOUR VISIT. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR NOTIFYING THE OFFICE OF ANY CHANGE IN MY INSURANCE COVERAGE BECAUSE FAILURE TO INFORM THE OFFICE MAY RESULT IN DENIAL OF INSURANCE PAYMENT, AND I WILL THEN BE RESPONSIBLE FOR PAYMENT IN FULL.**

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**INSURANCE RELEASE INFORMATION**

I HEREBY AUTHORIZE THE OFFICE OF Palm Beach Cardiovascular Clinic TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO Dr. Villa. **I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.**

**FINANCIAL RESPONSIBILITY POLICY**

I UNDERSTAND THERE IS A **CANCELLATION/NO SHOW FEE OF \$35.00 FOR OFFICE APPOINTMENTS** AND A **\$200.00 FEE FOR NUCLEAR STRESS TEST IF WE ARE NOT NOTIFIED 24 HOURS PRIOR TO APPOINTMENT**. I AM AWARE THERE IS A \$50.00 FEE FOR RETURNED CHECKS. I AM AWARE THAT **COPAYS, DEUCTIBLES, AND CO-INSURANCE AMOUNTS WILL BE COLLECTED AT TIME OF SERVICE**. THERE WILL ONLY BE TWO **STATEMENTS** SENT FROM THE OFFICE WITH PAYMENT DUE IN 30 DAYS BEFORE ANY ACCOUNT IS REFERRED TO A COLLECTION AGENCY.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PALM BEACH CARDIOVASCULAR CLINIC**  
**600 University Blvd Suite 200**  
**Jupiter, FL 33458-2778**  
**Phone: (561) 627-2210**  
**Fax: (561) 627-2130**

**HIPAA RELEASE FORM**

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security #: \_\_\_\_\_

I have Read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the practice with my authorization and consent to use and disclose my protected healthcare information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

I give permission to leave my medical and billing information on my home or cell phone answering machine or voice mail. YES  NO

**DISCLOSURE OF INFORMATION**

Palm Beach Cardiovascular Clinic may disclose my Private health information to the following individuals OUTSIDE THE MEDICAL FIELD pertaining to my CARDIAC condition.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

All Patients are required to complete this authorization form and return to Palm Beach Cardiovascular Clinic.