Saving Lives, One Heart Beat at a Time

Florida Cardiology Associates
3543 Little Road Suite- A
Trinity, Florida 34655
(727) 848-6400-Phone (727) 848-6200- Fax
Dr. Sudhir Agarwal MD, FACC, FSCAI, Dr Robert Ledbetter DO, FACC

Thank you for choosing Florida Cardiology Associates for your cardiology needs. We Have prepared this packet of information and forms in order to make your first visit with us, a convenient and pleasant experience. We ask that you complete the attached paperwork prior to your arrival.

When you come for your appointment please bring the following:

- Completed New Patient paperwork (**do not mail in**)
- Medical Insurance Cards and Photo ID
- Bring with you any records from your previous Cardiologist
- Please let us know if you have been seen in the hospital prior to your appointment
- Bring with you an updated Medication list with current milligrams and dose information

Please be prepares to pay for the following at the time of your visit:

- Co-payment. If your insurance requires a co-pay, your are responsible for this at the time of your appointment

- If you do not have insurance, payment is expected at the time of service (unless previous arrangements have been made)

Referral/Authorizations: We will attempt to get referral/authorization from your Primary care physician; however it is always a good idea for you to call to let them Know of your appointment.

Please check in 15 minutes prior to your scheduled appointment time to allow our staff to complete the administrative portion of your appointment.

Patient Information

Date: _____ Male or Female Are you Hispanic -Y or N Race: _____
Ht: _____ Wt_____

Name: (last) _____ (first) _____ (middle) _____

Social Security Number: _____ DOB: _____ Age: _____

E-Mail address- _____ Marital Status: S M D W Sep

Address: _____ City: _____

State: _____ Zip: _____ Home phone: _____ Work phone: _____

Secondary Address: _____

_____ Backup phone number: _____

Employed by: _____ Address: _____

Notify in Case of Emergency:

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Primary Physician: _____ Phone # _____

Insurance Information (Please have cards ready for receptionist)

Primary: _____ **Secondary:** _____

Policy # _____ Policy #_____

Group #_____ Group #_____

Guarantor :(name) _____ DOB: _____ SS# _____

Patient Health History

Patient Name: _____ SS# _____ Date: _____

Age: _____ DOB: _____ Reason for today's visit _____

Symptoms/Problems check all symptoms you currently have or have had.

General
__ Depression
__ Anxiety
__ Loss of Sleep
__ Loss of Weight
__ Nervousness
__ Sweats

Neurological
__ Dizziness
__ Fainting
__ Forgetfulness
__ Headache
__ Numbness
__ Tremors

Muscle/Joint/Bone pain
__ Arms __ Legs
__ Feet __ Hands
__ Neck __ Shoulders
__ Back __ Hips

Respiratory
__ Shortness of Breath
__ Cough
__ Sputum __ Blood
__ Wheezing
__ Tightness
__ Pain when breathing

Cardiovascular
__ Chest pain
__ High Blood Pressure
__ Irregular heart beat
__ Low Blood Pressure
__ Poor circulation
__ Rapid heart beat
__ Swelling of ankles
__ Varicose veins

Endocrine
__ Excessive thirst
__ Too hot/cold
__ Tired/Sluggish
__ other

Genitourinary
__ Blood in urine
__ Frequent urination
__ Lack of bladder control
__ Painful urination
__ Nighttime urination
__ Urine retention

Gastrointestinal
__ Poor Appetite
__ Bloating
__ Bowel Changes
__ Constipation
__ Diarrhea
__ Excessive hunger
__ Excessive thirst
__ Gas
__ Hemorrhoids
__ Indigestion
__ Nausea
__ Rectal bleeding
__ Stomach pain
__ Vomiting __ blood

Hematologic
__ Swollen glands
__ Blood clotting problems
__ Anemia

Skin
__ Bruise easily
__ Hives
__ Itching
__ Rash
__ Sore that won't heal

Eye, Ear, Nose, Throat
__ Bleeding gums
__ Blurred vision
__ Difficulty swallowing
__ Double vision
__ Hoarseness
__ Loss of hearing
__ Nosebleeds
__ Persistent cough
__ Vision-flashes

Conditions/Illness Check all conditions you currently have or have had

__ AIDS __ HIV positive
__ Alcoholism
__ Alzheimer's Disease
__ Anemia
__ Arthritis
__ Asthma
__ Bleeding Disorder
__ Blood Clot
__ Breast lump
__ Bronchitis
__ Cancer _____
__ Cataracts
__ Chemical dependency
__ Chronic pain _____
__ Diabetes _Insulin _Pills
__ Eating disorder
__ Emphysema
__ Epilepsy
__ Glaucoma
__ Goiter
__ Gout
__ Heart disease, if yes please explain _____
_____
__ Hepatitis __A __B __C
__ Hernia
__ High cholesterol
__ High Blood Pressure
__ Liver disease
__ Migraines
__ Miscarriage
__ Multiple Sclerosis
__ Pacemaker
__ Pneumonia
__ Prostate problems
__ Psychiatric care
__ Rheumatic fever
__ Scarlet fever
__ Thyroid problems
__ Tuberculosis
__ Ulcers
__ Other_____

Please fill out this page to its entirety

Family History Fill in health information about your family

Relation	*Age*	*State of health*	*Age of Death*	*Cause of Death*
Father				
Mother				
Sister				
Brother				

Please circle if any blood relatives had any of the following and their relation to you

Cancer _____
Chemical dependency _____
Diabetes _____
Heart Disease; Strokes (if yes please specify) _____
_____
High Blood Pressure _____
Kidney Disease _____
Tuberculosis _____

Hospitalizations/Surgeries/Serious Illness/Injuries

Year	Hospital	Reason for Hospitalization/outcome
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____

Heart Problems

Fill in date of your last:
EKG _____
Chest X-Ray _____
Lab _____
Physical _____

Exercise

Do you exercise (please circle)

No **Minimal** **Moderate**

Health Habits Check which substance you use and answer questions

__ Caffeine __coffee __ tea __ soda How many cups/day _____
__ Tobacco __cigarettes __ cigars __ pipe How many per day_____ How long _____
__ Previous tobacco use What kind _____ When did you stop _____
__ Recreational Drugs Kind _____ How often _____ How long _____
__ Alcohol use Kind_____ How often_____ How long _____

Other

Living Will __ yes __ no
Healthcare Proxy __ yes __ no
Durable Power of Attorney __ yes __ no
Do Not Resuscitate __ yes __ no

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of FCA responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____
Print: _____
Date: _____

Name: _____

Pharmacy: _____

Name location/cross street (if any) phone number

Allergies: _____, _____, _____

_____, _____, _____

_____, _____, _____

Medicine

Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

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Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

Medicine (name):_____ Dose:_____ How often:_____

Permission for Treatment

I, the undersigned, voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment by **FCA-Dr. Sudhir Agarwal, Dr. Robert Ledbetter, which is deemed advisable and necessary for** the diagnosis/treatment of my condition. I know that medicine is not an exact science, and I acknowledge that no guarantees have been made to me due to treatment or examination in the office. I authorize the release of any of my past or present medical records needed for my treatment from any prior healthcare providers.

Signature: _____ **Date**: _____

Authorization and Assignment

I request that Authorized Medicare/Insurance Benefits be paid to me or on my behalf for any services furnished by **FCA/Dr. Sudhir Agarwal, Dr. Robert Ledbetter.** I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits or benefits related to services.

Signature: _____ **Date:** _____

Designated Relative

I authorize the discussion and release of my general medical condition and diagnosis (including treatment, payment, and healthcare operations) with:

Please list the family members or significant others, if any, whom we may inform about your medical condition and in case of an emergency

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Messages may be left on my answering machine regarding my health and/or any appointments made _yes _no

Signature: _____ **Date:** _____

HIPAA Privacy Notice

I have received a copy of **FCA/ Dr. Sudhir Agarwal and Dr. Robert Ledbetter's** privacy notice.

Signature: _____ **print name:** _____ **Date:** _____

Arterial and Venous Screening Form

Name: _____

Date: _____

**Do you experience any of the following in your legs:*

1. *Aching Pain* ☐ Y ☐ N
2. *Heaviness* ☐ Y ☐ N
3. *Fatigue / tiredness* ☐ Y ☐ N
4. *Itching / burning* ☐ Y ☐ N
5. *Swelling / cramps* ☐ Y ☐ N
6. *Restless legs* ☐ Y ☐ N
7. *Throbbing* ☐ Y ☐ N
8. *Skin or ulcer problems* ☐ Y ☐ N

**Have you had a history of:*

1. *Sclerotherapy* ☐ Y ☐ N
2. *Laser therapy (spider veins)* ☐ Y ☐ N
3. *Phlebectomy* ☐ Y ☐ N
4. *Vein Stripping surgery* ☐ Y ☐ N
5. *RF Ablation* ☐ Y ☐ N
6. *Lower Extremity Revascularization* ☐ Y ☐ N

**When you walk or exercise, do you experience pain in your arms, thighs, legs or buttocks?* ☐ Y ☐ N

**If you answered yes, does the pain subside with rest?* ☐ Y ☐ N

**Do you have painful sores or ulcers on your legs that aren't healing?* ☐ Y ☐ N

**Do you have Diabetes?* ☐ Y ☐ N

**Have you had surgery, balloon procedures or stents to any blood vessels other than your heart?* ☐ Y ☐ N

**Have you experienced temporary Loss of vision, slurred Speech, or weakness / numbness in arm or leg?* ☐ Y ☐ N

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		SS#	

TO: (Name, Address, Phone of Recipient of Records)						
Name	Florida Cardiology Associates			Phone	727-848-6400 Fax:727-848-6200	
Address	3543 Little Rd.					
City/State Zip		Trinity		FL		34655

RECORDS FROM: (Who is Releasing the Records)						
Name				Phone		
Address						
City/State Zip						

For the Following Purposes:

✓	Continued Medical Care		Personal Information		Legal Follow-up
	Disability Insurance		Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

	Please send the entire Medical Record (all information) to the above named recipient.				
✓	Office Notes and Reports (Last)	✓	Diagnostic Reports		Billing Statements
✓	Rx History	✓	Transcribed Hospital Reports	✓	Laboratory Reports
✓	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases

_____ Mental Health Information and/or Records

_____ Domestic Violence

_____ Genetic Testing Information and/or records

_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

_____ Other: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to patient: _____