



M. Kevin Graves, M.D., F.A.C.C.

Patient Registration Form

972-620-9111
FAX: 972-620-9187

TODAY'S DATE: ___/___/___

RECORD NUMBER: _____

PATIENT INFORMATION (Please use full legal name, no nicknames) (Mr.) (Mrs.) (Ms) (Dr)

Last Name _____ First Name _____ Middle Initial _____

Who referred you to our practice _____

How would you like to be addressed by your physician _____

Address _____ City _____ State _____ Zip Code _____

Home Phone # (____) ____ - _____ Mobile/Pager # (____) ____ - _____ Other (____) ____ - _____ Social Security # ____ - ____ - ____

Date of Birth ___/___/___ Age ____ Sex ____ Marital Status: (Married) (Divorced) (Single) (Widowed) Drivers Lic # _____

Employer Name _____ Address _____

Work Phone # (____) ____ - _____ E-Mail Address _____

Emergency Contact Name _____ Relationship _____

Emergency Phone (____) ____ - _____ Pharmacy Name: _____ Phone # (____) ____ - _____

GUARANTOR INFORMATION: (List person responsible for bill – use full legal name, no nicknames)

Relationship of Guarantor to Patient : (Self) (Spouse) (Parent) (Other) _____

If self and contact information is same as above, check here

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip Code _____

Date Of Birth ___/___/___ Age ____ Sex ____ Home Phone (____) ____ - _____ Work Phone # (____) ____ - _____

Employer Name _____ Address _____ City _____ ST _____ Zip _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards and Driver's License)

Primary Insurance

Plan Name _____ Insured's Name _____

Insured's Social Security # ____ - ____ - ____ Insured's Date of Birth ___/___/___

Policy / ID # _____ Group # _____ Effective Date _____

Claims Address _____ Phone # (____) ____ - _____

Secondary Insurance

Plan Name _____ Insured's Name _____

Insured's Social Security # ____ - ____ - ____ Insured's Date of Birth ___/___/___

Policy / ID # _____ Group # _____ Effective Date _____

Claims Address _____ Phone # (____) ____ - _____



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ASSIGNMENT OF INSURANCE / PLAN BENEFITS:

I HEREBY AUTHORIZE DIRECT PAYMENT OF INSURANCE BENEFITS TO Dr. _____, physician for services rendered by the physician in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE NON-PUBLIC INFORMATION:

I certify that I have received and read a copy of the Heart First Patient Information Privacy Policy. I HEREBY AUTHORIZE Dr. _____, the physician or his employed agent, to release any medical or incidental information that may be necessary for either medical care or for processing insurance or financial benefits.

MEDICARE / MEDICAID INSURANCE:

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefit be made to the physician on my behalf.

LAB / X-RAY / DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if I receive lab, x-ray, or other diagnostic services. I understand that I am financially responsible for any balance not covered by my insurance for these services.

PATIENT NAME: (Please Print) _____ D.O.B. ____/____/____

SIGNATURE OF PATIENT: _____ DATE ____/____/____

SIGNATURE OF GUARANTOR: _____ DATE ____/____/____
(If different from patient)

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Patient Privacy



M. Kevin Graves, M.D., F.A.C.C.

Today's Date: ___/___/___

Name: _____ DOB ___/___/___ SS# _____ - _____ Sex: Male Female

What is the name of the doctor who referred you to us? _____ Name of your family M.D. _____

WHY ARE YOU HERE to see a Cardiology (heart) doctor? _____

PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY	DOCTOR TO FILL OUT
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Mark (X) on any HEART PROBLEMS or SYMPTOMS: Age: _____

<input type="checkbox"/> Heart attack	<input type="checkbox"/> Palpitations/Irregular heart beat	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Angina	<input type="checkbox"/> Leg cramps when you walk	<input type="checkbox"/> Swollen legs
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Enlarged heart	<input type="checkbox"/> Heart failure
<input type="checkbox"/> Blue lips or fingernails	<input type="checkbox"/> Chest pains or pressure	<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Abnormal rhythm (arrhythmias)	<input type="checkbox"/> Fainting

Mark (X) if you have ever had any of the following TESTS or PROCEDURES:
(Indicate approximate year of the test or procedure)

<input type="checkbox"/> Stress test _____	<input type="checkbox"/> Coronary bypass surgery _____	<input type="checkbox"/> Valve surgery _____
<input type="checkbox"/> Electrocardiogram _____	<input type="checkbox"/> Electrophysiology Study or Procedure _____	
<input type="checkbox"/> Cardiac catheterization/Heart catheterization _____	<input type="checkbox"/> Pacemaker or Defibrillator _____	
<input type="checkbox"/> Coronary Angioplasty (balloon / artherectomy / stent) _____		

Please mark (X) if you have:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Overweight	<input type="checkbox"/> High triglycerides
<input type="checkbox"/> High cholesterol: Total _____ LDL _____ HDL _____ T ₃ _____			
<input type="checkbox"/> Ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit (number of packs per day) _____			
<input type="checkbox"/> Presently smoking (number of packs per day) _____			

Has a close family member had:

A heart attack?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(Mother – Father – Sibling)
Angina?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bypass surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Carotid surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Surgery on their leg arteries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

For woman only: Could you be pregnant? Yes No
 Have you passed menopause (change of life)? Yes No
 At what age? _____ Do you take estrogen? _____

Are you being treated now or have you been treated for any illnesses?
Please list them:
 1. _____ 3. _____
 2. _____ 4. _____

Have you ever had any operations? Any injuries? (Please include date or year.)
 1. _____ 3. _____
 2. _____ 4. _____

Social History:
 What is your MARITAL STATUS?
 Single (never married) Widowed Separated
 Married Divorced
 Spouse name _____ Number of Children _____
 OCCUPATION: _____
 MAJOR HOBBY: _____

HISTORY OF PRESENT ILLNESS:

Onset _____

Frequency _____

Location _____

Quality _____

Severity _____

Timing _____

Duration _____

Associations _____

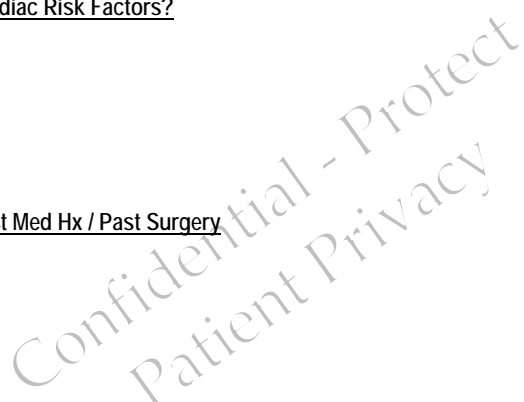
Aggravating _____

Alleviating _____

Cardiac Risk Factors?

Past Med Hx / Past Surgery

Social Hx / Family Hx



PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY

DOCTOR TO FILL OUT

Please tell us about your medicines (names, dose or strength, how many times a day). Include over-the-counter medications and herbal medicines. Use doctor's column if necessary.

Medicines:

	Name	Dose	Frequency
1.	ASPIRIN YES / NO	81mg / 325mg	Enteric Coated YES / NO
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____

Over the Counter Medications / Herbs

1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Allergies:

Allergies:

Do you have any DRUG ALLERGIES? Yes No (if yes, list them below)

Are you allergic to IODINE, shrimp or shellfish? Yes No

Have you ever had a reaction to contrast dye? (e.g. Myelogram, kidney Series, CAT scan) Yes No

Have you had the following vaccinations?

- Influenza ("Flu Shot") Annually
- Pneumococcal ("Pneumonia") vaccine

Vaccinations:

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PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY

DOCTOR TO FILL OUT

REVIEW OF BODY SYSTEMS: Please mark (X) YES or NO to each SYMPTOM you have.

<u>CONSTITUTIONAL</u>	NO	YES	<u>GASTROINTESTINAL</u>	NO	YES
FEVER	<input type="checkbox"/>	<input type="checkbox"/>	NAUSEA	<input type="checkbox"/>	<input type="checkbox"/>
CHILLS	<input type="checkbox"/>	<input type="checkbox"/>	VOMITING	<input type="checkbox"/>	<input type="checkbox"/>
NIGHT SWEATS	<input type="checkbox"/>	<input type="checkbox"/>	HEARTBURN	<input type="checkbox"/>	<input type="checkbox"/>
Weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>	ABDOMINAL PAIN	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD IN STOOL	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
			Constipation	<input type="checkbox"/>	<input type="checkbox"/>
			Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
			Black or Tarry Stools	<input type="checkbox"/>	<input type="checkbox"/>

<u>Eyes</u>	NO	YES	<u>Musculoskeletal</u>	NO	YES
SEE SPOTS	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>			
Yearly Exams	<input type="checkbox"/>	<input type="checkbox"/>			

<u>Ears</u>	NO	YES	<u>Genitourinary</u>	NO	YES
RINGING	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY STONES	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Burning with urine	<input type="checkbox"/>	<input type="checkbox"/>
			Difficulty starting or stopping urination	<input type="checkbox"/>	<input type="checkbox"/>

<u>Nose / Throat / Mouth</u>	NO	YES
NOSEBLEEDS	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing Trouble	<input type="checkbox"/>	<input type="checkbox"/>

<u>RESPIRATORY</u>	NO	YES	<u>Men</u>	NO	YES
SHORT OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	Erectile Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
COUGH	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cough Blood	<input type="checkbox"/>	<input type="checkbox"/>			
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			

<u>Hematologic</u>	NO	YES	<u>NEUROPSYCHIATRIC</u>	NO	YES
PROLONGED BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>
			Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
			Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>

PHYSICAL EXAM

Height _____ Weight _____

BP: (Rt) _____ (Lt) _____

Pulse _____ Resp _____

PHYSICAL FINDINGS

HEENT:

PULM:

CARDIAC / PULSES:

ABD:

EXTREMITIES:

NEURO:

TESTING:

ASSESSMENT:

- 1.
- 2.
- 3.
- 4.

MEDICAL DECISION MAKING

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Dictated: _____
Initials / Date

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TODAY'S DATE: ___/___/___

RECORD NUMBER: _____

RELEASE OF MEDICAL INFORMATION

(PLEASE PRINT)

Patient's Full Name: _____
(First / MI / Last)

Patient's Address: _____ City: _____ State: ____ Zip: _____

Home Telephone Number: () _____ - _____ Date of Birth ___/___/_____ Social Security No _____ - ____ - _____

MEDICAL RECORDS REQUESTED FROM: DOCTOR / ADDRESS / PHONE

I, hereby request that my complete medical records be released to Dr. _____ for his use in my medical care. This consent is only for the release of medical records and should include all medical notes, lab studies, surgical reports, x-ray reports, EKG's and other diagnostic reports. Please expedite my request and mail my medical records to:

M. Kevin Graves, M.D., F.A.C.C.

**1675 Republic Parkway, Suite 100 Mesquite, TX 75150
972-620-9111
Fax:972-620-9187**

Patient Signature: _____ Date: ___/___/_____

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Notice of Patient Information Privacy Policies

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

September 1, 2001

1. What is the purpose of this notice?

The purpose of this notice is to advise you of the information and patient privacy policies that are part of the HeartFirst medical practice. In order to provide your healthcare and at the same time effectively manage our medical practice we must collect non-public personal information about you. We want you to know that we consider this information private and confidential, and that we have policies and procedures in place to protect this information against unlawful use and/or disclosure. This notice describes, to the best of our abilities, the types of information we collect and when, how and for what purposes it may be disclosed to others. If you have questions about this information or our policies and procedures please don't hesitate to call our Director of Patient Privacy and Information Protection in Human Resources at 972-739-2640.

2. What is "Non-public Personal Information"?

Non-public personal information ("NPI") is information specific to and may serve to identify an individual who is currently receiving or who has received medical care from our medical practice. Among other things, this information may include details about the person's physical or mental health, the medical care evaluation, testing and treatment they may have received, and other information relating to payment for these various services. NPI does not include information that is publicly available or information that is available or reported in a summarized or aggregated fashion that does not identify individual patients.

3. How is Non-public Personal Information protected?

HeartFirst is required by law to restrict access to NPI to those healthcare providers, employees and vendors of business services to the medical practices who must have access to the information in order to provide you with the best possible medical care. **HeartFirst** maintains physical, electronic and procedural safeguards to protect NPI against unauthorized access and disclosure. The Director of Patient Privacy and Information Protection, along with other employees who are engaged as needed, has overall responsibility for developing, educating employees about, and overseeing the enforcement of policies and procedures to safeguard NPI against inappropriate access, use or disclosure, consistent with applicable laws.

4. What personal information might be disclosed to outside third parties, and for what purposes?

HeartFirst does not disclose NPI to anyone, except with patient authorization or as otherwise permitted by law. Disclosures permitted by law include the following:

- Whenever necessary for the patient's care and treatment or related activities, NPI is shared internally within the practice of **HeartFirst**.
- Whenever necessary for the patient's care and treatment or related activities, NPI is shared externally with other healthcare providers (doctors, physician's assistants, dentists, pharmacists, hospitals or other caregivers), insurers, third party administrators, payors (employers who sponsor self-funded health plans, health care provider organizations, and others who may be financially responsible for payment for the services or benefits that a patient may receive under the terms of a healthcare plan), vendors, consultants, government authorities, and their respective agents. For example, NPI may be provided to your insurer as they attempt to determine the medical necessity of testing and treatment recommended to you by a referring physician. All of these external parties are required in turn to keep your NPI confidential as provided by applicable law.

Notice of Patient Information Privacy Policies

In addition to the uses described above, **HeartFirst** routinely utilizes NPI to provide patient appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.

On your first visit to **HeartFirst** you will be asked to sign an authorization for the permitted uses of NPI. **HeartFirst** will not use NPI for any purpose other than those falling within the scope of the above policy statement without the patient's written permission to do so. You have the right at any time to revoke this authorization in writing to your **HeartFirst** healthcare provider.

5. How may a patient request other disclosures of personal information?

Should you wish to have a copy of your own NPI you may request it by calling the Director of Patient Privacy and Information Protection at the telephone number listed in Section 1. above. You must complete a written NPI Copy Request Form and **HeartFirst** will arrange a time for you to review your NPI and decide which pages, if any, you desire to have copied. **HeartFirst** will charge you \$1 per page to help to defray the costs of locating and duplicating this information. Applicable law provides that you have the right to notify us of any errors or inconsistencies in your NPI and that we maintain a record of your comments and amendments in this regard.

Should you wish us to disclose your NPI to other third parties or for reasons other than those addressed in Section 4. above, you must also complete a written NPI Copy Request Form and **HeartFirst** will decide, on an individual case basis, whether or not a charge for this service is applicable depending upon the proposed use of the NPI. In general, the provision of NPI for the purposes of on-going medical care or payment for services will be done at no charge, while that for all other purposes will involve a charge.

You also have the right under current law to request restrictions on certain uses and disclosures of your NPI permitted under applicable law, though current law does not require **HeartFirst** to necessarily agree to honor the requested restrictions.

6. What does HeartFirst do with personal information if and when you no longer obtain your medical care through our practices?

NPI is not destroyed when patients leave our care. The information continues to be available for use for all of the purposes described in Section 4. above, and in most cases is subject to legal retention requirements (typically, 7 years).

7. How is this notice being distributed?

This notice will be provided to all new **HeartFirst** patients at the time of their first visit. Current patients will receive a copy as they visit our offices in the course of their usual healthcare activities over the coming months. *HeartFirst reserves the right to change the terms of this notice and to substitute the provisions of the new notice in regards to all NPI we maintain. HeartFirst is required by law to make all reasonable effort possible to see that you receive a copy of the new notice if and when any policy changes are made.*

8. What to do if you have reason to believe we may have violated our own patient information and privacy policies?

If you believe our Patient Information and Privacy Policies have been violated with respect to the NPI of yourself or your dependents, please contact our Director of Patient Privacy and Information Protection in Human Resources at 972-739-2640. We will be happy to provide a copy of our internal grievance procedures regarding these issues upon your request to do so.

12/2006



Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Heart First reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the "Notice of Privacy Practices"

Name of Patient (Print)

Signature of Patient

Date of Signature

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

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Please place in the patient's medical record.

12/2006



In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please circle your response to the following:

May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answers your calls? Yes No N/A

May we leave **messages** on a voice mail or answering machine regarding **appointments/treatment** at work or home? Yes No N/A

May we discuss your **appointments/treatment** with your spouse? Yes No N/A

May we discuss your **appointments/treatment** with your children who are over the age of 18? Yes No N/A

If you are over the age of 18, may we discuss your **appointments and/or treatment** with your parents? Yes No N/A

You must inform us, **in writing**, of any changes in your directives. This record takes effect September 1, 2005, and will be kept in your file.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Home number: _____ Work number: _____