APEX
CARDIOLOGY OF HOUSTON

Today's Date:_____

PATIENT INFORMATION			
Last Name:	First Name:		M.I.:
Date of Birth:	Social Security #:	Sex: ☐ M ☐ F	Marital Status:
Mailing Address:			Apt #:
City:	State:		Zip Code:
Home Phone:	Cell Phone:		Work Phone:
Preferred Method for Reminder Calls: ☐ Voice ☐ Text If Voice, Select Preferred Number: ☐ Home ☐ Cell ☐ Work			
E-Mail Address:			Register for patient portal? ☐ Yes ☐ No
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Black/African American ☐ White/Caucasian ☐ Hispanic ☐ Other Race ☐ Decline			
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline			Preferred Language:
Employment Status: ☐ Employed ☐ Unemployed ☐ Self Employed ☐ Student ☐ Retired			
Employer Name:			Employer Phone:
Emergency Contact Name:			Emergency Contact Phone:
Relationship to Patient:			

INSURANCE INFORMATION	
Primary Insurance	**Secondary Insurance**
Ins. Co. Name:	Ins. Co. Name:
ID #:	ID #:
Group #:	Group #:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder Social Security #:	Policy Holder Social Security #:
Relationship to Policy Holder:	Relationship to Policy Holder:

Patient Signature

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Apex Cardiology of Houston, PLLC or insurance company to release any information required to process my claims.

Patient Printed Name:	**Date:**
Patient Signature:	

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Past Medical History

☐ Diabetes (Type 1 or 2)	☐ Psoriasis	☐ Emphysema	☐ Colitis
☐ High blood pressure	☐ Angina	☐ Stroke	☐ Anemia
☐ High cholesterol	☐ Heart problems	☐ Epilepsy(seizures)	☐ Jaundice
☐ Hypothyroidism	☐ Heart murmur	☐ Cataracts	☐ Hepatitis (A – B – C)
☐ Goiter	☐ Pneumonia	☐ Kidney disease	☐ Stomach or peptic ulcer
☐ HIV/Aids	☐ Pulmonary Embolism	☐ Kidney stones	☐ Rheumatic Fever
☐ Leukemia	☐ Asthma	☐ Crohn's disease	☐ Tuberculosis
☐ Cancer (type):_____		☐ Other (please list):_____	
☐ Obstructive Sleep Apnea (OSA)		☐ Continuous positive airway pressure therapy (CPAP)	

Surgical History

Date (Month/Year)	Name of Surgery

Hospitalizations

Date (Month/Year)	Reason for Hospitalization

Family History

Family	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Mental Disease	Unknown
Father							
Mother							
Sibling							
Sibling							
Children							
Children							

Social History

Tobacco Use:

Are you a ☐ current smoker ☐ former smoker ☐ non smoker ☐ uses tobacco in other forms

If current smoker, how many cigarettes a day do you smoke? ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

Drugs/Alcohol:

Have you used drugs other than those for medical reasons in the past 12 months? ☐ yes ☐ no

Do you drink alcohol? ☐ yes ☐ no ☐ socially ☐ daily

Caffeine Use:

Intake: ☐ None ☐ 1-2 cups per day ☐ 2-3 cups per day ☐ 3-4 cups per day ☐ more than 4 cups per day

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MEDICATION LIST		
Please list ALL the medications you are currently taking. Include ALL prescription medications, non-prescription medications, vitamins, herbal remedies and supplements. If you have a list of medications, please provide the list at time of check-in.		
Name of Medication	**Dose / Strength**	**How Often**
Example:*Lasix*	*40 mg*	*Twice daily*

ALLERGIES/INTOLERANCE TO MEDICATION(S)	
Name of Medication	**Reaction**
Example:*Sulfa Drugs*	*Hives, Swelling*

PHARMACY INFORMATION		
Pharmacy Name:		Pharmacy Phone:
Pharmacy Address:		
City:	State:	Zip Code:
I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy. ☐ **YES** ☐ **NO**		

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Physician Information		
Primary Care Physician		Phone #:
Referring Physician		Phone #:

Review of Systems
(Please check either YES or NO)

	YES	NO
GENERAL		
Significant weight loss	☐	☐
Significant weight gain	☐	☐
EAR, NOSE, THROAT		
Excessive snoring	☐	☐
RESPIRATORY		
Coughing up blood	☐	☐
GASTROINTESTINAL		
Blood in stools (black stools)	☐	☐
GENITOURINARY		
Blood in urine	☐	☐
VASCULAR		
Calf pain with walking	☐	☐
Varicose veins	☐	☐
Restless leg syndrome	☐	☐
MUSCULOSKELETAL		
Muscle pain at rest	☐	☐
NEUROLOGICAL		
Dizziness	☐	☐
PSYCHIATRIC		
Excessive stress	☐	☐
ENDOCRINE		
Feel cooler than others	☐	☐
HEMATOLOGICAL		
Unusual Bleeding	☐	☐

	YES	NO
CARDIAC		
Chest pain	☐	☐
Chest pressure	☐	☐
Shortness of breath	☐	☐
Difficulty breathing while laying flat	☐	☐
Awakening with breathing difficulty	☐	☐
Swelling in feet/ankles	☐	☐
Palpitations	☐	☐
Nearly passing out spells	☐	☐
Passing out spells	☐	☐

Any other reason why you need to see a cardiologist?

_____

_____

_____

_____

_____

_____

_____

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Houston, TX 77089
P. 281-922-9239
F. 855-518-5437

GENERAL CONSENT FOR CARE AND TREATMENT

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or other health care providers or the designees as deemed necessary, of APEX CARDIOLOGY OF HOUSTON, PLLC to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

MEDICAL POWER OF ATTORNEY

Do you have a Medical Power of Attorney Representative? ☐ Yes ☐ No

Name:	Phone:

RELEASE OF INFORMATION

I authorize Apex Cardiology of Houston, PLLC to release my medical and/or billing information to the individual(s) listed below:

Name	Relationship	Phone Number

- I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.
- I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.
- You have the right to revoke this consent in writing.

Patient Printed Name:	Date:
Patient Signature:	