Established Patient Form (Dr. Villa)
Palm Beach Cardiovascular Clinic

PATIENT NAME: _____ DATE: _____/_____/_____

Chief complaint:

_____

_____

	Yes	No	Type and frequency
Do you Exercise?			

Have you experienced since last office visit:

	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				
_____				
_____				

New illnesses since last office visit:

_____

_____

_____

Operations since last office visit: (Year) Hospital

1) _____ _____

2) _____ _____

Medications/Supplements: Doses

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Social History:

Alcohol:_____ Coffee: _____

Smoking: _____ Recreational Drugs: _____

Comments: _____

Reviewed by Dr. Villa:

_____

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

Yes	General
☐	Weakness
☐	Fever
☐	Chills
☐	Night Sweats
☐	Fainting

Yes	Eyes
☐	Blurred Vision
☐	Glaucoma
☐	Redness
☐	Itching
☐	Burning
☐	Swelling
☐	Pain
☐	Dryness
☐	Tearing

Yes	Ears
☐	Hearing difficulty
☐	Deafness
☐	Discharge
☐	Ringing
☐	Earache
☐	Itching
☐	Dizziness

Yes	Head
☐	Headaches
☐	Injuries
☐	Bumps

Yes	Mouth
☐	Bleeding Mouth
☐	Ulcers
☐	Dental problems
☐	Mouth Pain
☐	Bad Breath
☐	Loss of Taste

Yes	Nose
☐	Decreased Smell
☐	Bleeding
☐	Pain
☐	Discharge
☐	Obstruction
☐	Deviated Septum
☐	Runny Nose
☐	Sinus Congestion

Yes	Lungs
☐	Mucous
☐	Coughing blood
☐	Wheezing
☐	Chest Congestion

Yes	Blood
☐	Anemia
☐	Bruising
☐	Prolonged Bleeding
☐	Swollen Nodes
☐	Red Dots/Spots
☐	Blood Clots

Yes	Genitourinary
☐	Urgency
☐	Incontinence
☐	Straining
☐	Flank Pain
☐	Stones
☐	Burning
☐	Bed Wetting
☐	Small Stream
☐	Urethral Discharge
☐	Dripping
☐	Cloudy Urine
☐	Unusual Color
☐	Urination at Night
☐	Hesitancy

Yes	Psychiatric
☐	Hyper-ventilation
☐	Insecurity
☐	Depression
☐	Insomnia
☐	Irritability
☐	Anxiousness / Stress
☐	Indecisiveness
☐	Timid / Shy / Bashful
☐	Hallucinations
☐	Suicidal Thoughts
☐	Worrying
☐	Obsessive
☐	Panic Attacks

Yes	Neurological
☐	Seizures
☐	Vertigo
☐	Sensation Loss
☐	Trembling Hands
☐	Uncoordinated
☐	Expression loss
☐	Weak Grip
☐	Paralysis
☐	Slurred Speech
☐	Memory loss
☐	Disorientation
☐	Gait Shuffling
☐	No Concentration

Yes	Gastro-intestinal
☐	Abdominal Pain
☐	Nausea
☐	Vomiting
☐	Belching
☐	Heartburn
☐	Indigestion
☐	Irreg. Bowel Movements
☐	Constipation
☐	Diarrhea
☐	Gas
☐	Hemorrhoids
☐	Hernias
☐	Poor Appetite
☐	Food Intolerance
☐	Bloody Stool
☐	Black Tarry Stools
☐	Excessive Appetite

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.