Date:

Name **Date of Birth:**

Personal History

Present Illness (in your own words)

None ☐ Preventative Visit ☐

Please list all past illnesses, hospitalizations and injuries (date included):

None ☐

Please list all your medications, dosage and number of times taken daily:

None ☐

Primary Pharmacy: **Phone: ( )** **Fax: ( )**

Address: **State** **Zip Code**

Employer:

Occupation:

Please list any medications and /or substances to which you are allergic; give the type of reactions (e.g.: hives, wheezing, nausea, etc that you have experienced)

None ☐

Family History	If Living			If Deceased	
	AGE		HEALTH (Poor, Good, Excellent)	Age at Death	CAUSE
FATHER					
MOTHER					
Husband/Wife					
BROTHERS & SISTERS	Sex	AGE			
	M F				
	M F				
	M F				
SONS & DAUGHTERS	SEX	AGE			
	M F				
	M F				
	M F				

Do you know of any blood relative who has or had: (circle and give relationship)

Stroke	Epilepsy	Heart Attack
Cancer	Colitis	Stomach Ulcer
High Blood Pressure	Migraines	Kidney Disease
Tuberculosis	Asthma	Goiter
Diabetes	Hay Fever	Arthritis
Leukemia	Bleeding disorders	Mental Illness
Hyperlipidemia	High Cholesterol	Nervous Breakdown
Rheumatic Heart	Congenital Heart Disease	Suicide

Do you smoke? Cigarettes _____Pipe _____Cigars _____Year Started?_____

Were you exposed to second hand smoke in the past? Yes No

How many caffeinated beverages do you drink per day? Coffee _____Tea _____Soft Drinks _____

Do you drink alcoholic beverages? Occasionally (1-3 per month) ____ Regularly (1-2 per week) ____

Daily (1-3 per daily) ____ Continually (4+ per day) ____ Other _____

Confidential Channel Communication Request
Orange County Heart Institute and Research Center

As required by the Health Information Portability and Accountability Ace of 1996, you have the right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making this request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

Please select all that apply. Where you list more than one communication option, please indicate which you prefer,

_____ Phone
I want you to contact me by telephone at _____

☐ Do ☐ Do Not Leave messages on my voice mail – Cell
☐ Do ☐ Do Not Leave messages with any other person

I give approval to discuss or leave messages regarding personal health information with the following person (s) only: _____

_____ Mail
I want you to contact me at the following address:

_____

_____

_____ Email
I want you to contact me at the following Email address: _____

I give approval to discuss or leave messages regarding personal health information with the following persons only: _____

Emergency contact name: _____ Telephone: _____

Responsibility of Payment:
By signing below, I understand that I am financially responsible for all services provided by Orange County Heart Institute. I understand that I am responsible for all payments whether there is insurance coverage or not. OCHI will bill my insurance as a courtesy only.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit agency.

Signed_____**Date** _____

Print Name_____
If not signed by the patient, please indicate:
Relationship:_____ **Guardian or conservator of an incompetent patient**
_____ **Beneficiary or personal representative of deceased patient**

Orange County
Heart Institute
and Research Center

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO DESIGNATE RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

I, _____hereby voluntarily authorize the disclosure of information from my health record. (Name of Patient)

Patient Name: _____Date of Birth: _____

Phone Number: _____

Who is your Cardiologist: _____

Information we are allowed to give: Lab Results, Future Appointments, Medication Information i.e. last refill /refill request. (No other information will be given)

You must have a power of attorney on file to allow a designated person to make changes to the care plan or request to speak to a provider or the assistant regarding any detailed medical information.

By signing this request, you are allowing this office to disclose certain information. We will only provide the information to your designated family member/s, Spouse, Relatives named by you below.

I have a power of attorney on file here at OCHI: Yes / NO

Name of person/s you allow us to release medical information:

1. _____
2. _____
3. _____

_____ _____

Patient's Signature or Representative Date

This Information is to be released for the purpose stated above and may not be used for any other purpose.

FILE IN THE CHART

HIPAA Authorization for release of Medical Information