



Kedarnath Vaidya, M.D.

Patient Information

Patient Name: _____
Last Name First Name Middle Initial

Address: _____
Street City State Zip Code

Telephone _____
Home Work Cell

Social Security Number _____ (Male) _____ (Female) _____

Date of Birth _____ Marital Status (Married) (Single) (Widow) (Divorced) (Student)
Month Day Year

Name of Primary /Referring Physician: _____

Emergency Contact _____ Relation: _____

Phone Number: _____

Insurance Information

Name of Insurance Company _____

Policy Number _____ Group Number _____

Name of Policy Holder _____ Relationship to Patient (Self) (Spouse) (Child) (Other)

Policy Holder's Date of Birth _____ Social Security Number _____
Month Day Year

Policy Holder's Employer _____
Name Street Address City State Zip Code

Policy Holder's Address (If different from above) _____
Street Address City State Zip Code

Secondary Insurance _____ Name of Policy Holder _____

Policy Number _____ Group Number _____

Assignment of Benefits and Release of Information Authorization

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above and assign all benefits directly to Cardiovascular Clinic of Texas, if any, otherwise payable to the services rendered. I understand that I am financially responsible for all charges whether or not paid for by my insurance company.

I hereby authorize the doctor(s) to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

I certify that I have received, read and understand all documents given to me in regards to HIPAA act as a patient..

Signature of Patient or Guardian

Date

PATIENT MEDICAL HISTORY

TODAY'S DATE _____ **PATIENT'S NAME** _____ **DOB** _____ **AGE** _____
ALLERGIES _____

FAMILY HISTORY
 DIABETES _____ TB _____ HBP _____ STROKE _____ KIDNEY DISEASE _____ CANCER _____ HEART DISEASE _____ ARTHRITIS _____ ANEMIA _____ MENTAL ILLNESS _____
 MOTHER _____ FATHER _____
 LIVING _____ DECEASED _____ AGE _____ CAUSE OF DEATH _____ LIVING _____ DECEASED _____ AGE _____ CAUSE OF DEATH _____

YOUR DAILY ACTIVITIES/EXERCISES _____ **YOUR OCCUPATION** _____ **EDUCATION (HIGHEST LEVEL ACHIEVED)** _____
 SMOKING - PAST/PRESENT _____ HOW MUCH PER DAY? _____ ALCOHOL HOW MUCH? _____ CAFFEINE (COFFEE, TEA, COLAS) _____ HOW MUCH? _____

PAST MEDICAL HISTORY (CHECK EACH BOX THAT APPLIES TO YOUR HEALTH)

<p>GENERAL _____ Rheumatic Fever _____ Measles _____ Chicken Pox _____ Mumps</p> <p>EYES _____ Glaucoma _____ Cataracts</p> <p>EAR NOSE & THROAT _____ Vertigo _____ Ear Disease</p> <p>CARDIOVASCULAR _____ Heart Trouble _____ High Blood Pressure _____ Murmur _____ Fainting Spells _____ Congestive Heart Failure</p> <p>SURGERIES (List Surgeries with Dates) _____</p>	<p>RESPIRATORY _____ Emphysema _____ Pneumonia _____ TB</p> <p>DIGESTIVE _____ Jaundice _____ Hepatitis _____ Gallbladder Problem</p> <p>GENITOURINARY _____ History of Sexually Transmitted Disease _____ Kidney Disease _____ Kidney Ston</p> <p>FEMALE Age of Onset of Periods _____ Age of Onset of Menopause _____ How Many Pregnancies _____ How Many Children _____</p>	<p>BLOOD & GLANDS _____ Anemia _____ Bleeding Disorder _____ Cancer</p> <p>MUSCULOSKELETAL _____ Degenerative Arthritis _____ Rheumatoid Arthritis _____ Gout _____ Lupus (SLE)</p> <p>NEURO _____ Seizures _____ Paralysis</p> <p>PSYCHIATRIC _____ Depression _____ Anxiety _____ Manic Depressive Illness</p>	<p>ALLERGIC/IMMUNOLOGIC _____ Asthma _____ Hives or Eczema</p> <p>CARDIOVASCULAR TESTS _____ Last Cardiac Catheterization _____ Last EKG _____ Last Nuclear Medicine Study _____ Last Echocardiogram Other _____</p> <p>ENDOCRINE _____ Thyroid Disease _____ Diabetes</p>
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DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?

<p>GENERAL _____ Usual Weight _____ _____ Weight Loss _____ Weakness _____ Fatigue _____ Fever</p> <p>EYES _____ Last Eye Exam _____ _____ Glasses/Contacts _____ Pain _____ Double Vision</p> <p>EAR, NOSE & THROAT _____ Difficulty Hearing _____ Ringing in Ears _____ Sinus Trouble _____ Nasal Stuffiness _____ Nosebleeds _____ Frequent Sore Throat _____ Hoarseness _____ Last Dental Exam _____</p>	<p>CARDIOVASCULAR _____ Pain _____ Palpitation _____ Dizziness _____ Fainting Spells _____ Shortnes of Breath _____ Swelling of Ankles or Other Areas</p> <p>RESPIRATORY _____ Stiffness _____ Coughing Up Blood _____ Wheezing</p> <p>DIGESTIVE _____ Heart burn _____ Nausea _____ Vomitting _____ Change in Bowel Movements _____ Stomach Ulcers _____ Constipation _____ Diarrhea _____ Difficulty Swallowing</p>	<p>GENITOURINARY _____ Frequent or Painful Urination _____ Get up at Night to Urinate _____ Blood Urine _____ Difficulty Urinating</p> <p>MUSCULOSKELETAL _____ Depression _____ Joint Pain/Swelling _____ Muscle Pain _____ Back Pain</p> <p>NEUROLOGICAL _____ Weakness _____ Numbness _____ Tremors</p> <p>SKIN _____ Rash _____ Sores</p>	<p>VASCULAR _____ Pain on Legs or Hips When Walking _____ Swelling in Feet _____ Bluish Color in Feet</p> <p>PSYCHIATRIC _____ Anxiety _____ Recreational Drug Use _____ Manic Depressive Illness</p> <p>ENDOCRINE _____ Heat/Cold Intolerance _____ Excessive Thirst</p> <p>ALLERGIC/IMMUNOLOGICAL _____ Hay Fever _____ Other _____</p>
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CURRENT MEDICATIONS AND DOSAGES:

Cardio-Vascular Clinic of Texas
506 Graham Dr. #230
Tomball, TX 77375

Kedarnath Vaidya, M.D.

Phone 281-351-8500
Fax 281-516-9420
www.houstonheart.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Cardio-Vascular Clinic of Texas: () release to: () receive from:

Person or Organization Address

Phone Fax (If applicable)

Information/copies form the medical records on:

Patients Name Date of Birth SS#

Date(s) of Service

INFORMATION TO BE RELEASED: (Please circle all that apply)

Emergency Room	Radiology Reports	Lab Work	Radiology Films
History and Physical	Drug/Alcohol Information	Pathology Report	Billing Records
Consultations	Psychiatric Information	HIV Test Results	Cath Lab Film
Operative Report	Discharge Summary	AIDS Information	
Other _____			

This information is being released for the following purpose: (Please circle all that apply)

Continued Care	Attorney/Litigation	Insurance	Disability Services
Other _____			

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire (180) days from the date of my signature, unless specified in writing here _____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company of non-health care provider; the released information may no longer be protected by the federal and state privacy regulations.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

Signature of Patient of Legally Authorized Representative Date

Printed Name of Legally Authorized Representative Relationship to Patient

Witness – Printed Name/Signature Date

Patient or Legally Authorized Representative Driver's License/ID#