LONESTAR HEART AND VASCULAR

479 Oxford Dr. Ste. 104
New Braunfels, TX 78130
Phone: 830-214-0300
Fax: 830-214-0397

Patient Demographic Information

Patient Information

Patient's Name (Last, First, Middle):		Suffix	Preferred Name:	Former Last Name:
Sex: □ Male □ Female	Date of Birth:	Social Security #	Marital Status: □ Married □ Widowed □ Single □ Separated	
Address:			City, State, Zip:	
Home Phone:	Cell Phone:		Work Phone:	
Patient Email:				
Preferred Language:		Race:	Ethnicity: □ Hispanic □ Non-Hispanic	

Provider Information

Primary Care Physician:	Referring Physician:

Communication

□ I authorize Lone Star Heart & Vascular, and those parties acting on their behalf, to contact me about appointments and reminders for health services via: □ Phone □ Email □ Mail
Is it okay to leave confidential medical information on your answering machine and/or voicemail? □ yes □ no

Guardian

Name (Last, First, Middle, Suffix):

Emergency Contact

Name:	Relationship:	Phone:

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Insurance

Primary Insurance Company:	Subscriber's Name (policy holder):
Subscriber's Date of Birth:	Patient's Relationship to Subscriber:
Secondary Insurance Company:	Subscriber's Name (policy holder):
Subscriber's Date of Birth:	Patient's Relationship to Subscriber:

Clinical Information

Preferred Pharmacy:
Preferred Lab:

Financial and Treatment Consent

By signing my name below:

- I hereby guarantee payment in full within thirty (30) days of all charges established by Lone Star Heart & Vascular for services rendered to me or my dependent, unless other arrangements satisfactory to Lone Star Heart & Vascular have been made. This includes any charges that a third-party payer may determine to exceed usual and customary limits.
- I understand and acknowledge that if any unpaid amount owed by me are assigned to a third party for collection, I will be responsible for paying attorney fees, interest, court costs, and other costs of collection, including but not limited to collection agency fees.
- I authorize Medicare, Medicaid, and all relevant commercial payers to pay Lone Star Heart & Vascular on my behalf for any services furnished to me or my dependent. I certify that I have read this assignment of benefits, that the information given by me is correct, and that I agree to all the provisions contained in it.
- I understand that if I am facing financial difficulty, I can speak with a Lone Star Heart & Vascular associate to arrange a payment plan.
- The insurance information I have provided is current and correct. If I sign this form and the insurance card is found later to be outdated or invalid, I understand that I am responsible for paying for services in full and will need to file with the insurance carrier myself.
- I hereby consent to treatment by Lone Star Heart & Vascular Providers, mid-level, and all other office personnel. I understand that Lone Star Heart & Vascular will release my health information to my referring and/or subsequent healthcare providers, and as needed to process claims. I agree that this consent is valid for all treatment(s) and payment(s) of said treatment.
- I understand my insurance co-pay is due at the time of service, per my insurance company policy.
- Our clinic policy requires a 24-Hour cancellation notice for all appointments. If you do not show or give the clinic 24-hour notice, you will be billed $25.00. If you repeatedly neglect this policy, you may be dismissed as a patient.

Patient / Guarantor / Guardian Signature:	Date:

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HIPAA Disclosure Form

Patient Name:	Date of Birth:
Street Address:	City, State, Zip:
Phone Number:	Email address:
May we leave confidential information on your voicemail? □ yes □ no	

I, the above patient, hereby authorize **Lone Star Heart & Vascular** to release my medical information (appointments, labs/imaging results, diagnosis, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name:	DOB:	Relation:
Name:	DOB:	Relation:
Name:	DOB:	Relation:
Name:	DOB:	Relation:
Name:	DOB:	Relation:

I further release my medical information to the following physicians, clinics, and/or hospitals:

Physician:	Clinic:	Phone:
Physician:	Clinic:	Phone:
Physician:	Clinic:	Phone:
Physician:	Clinic:	Phone:
Physician:	Clinic:	Phone:

Patient / Patient Representative Signature:
Printed Name of Representative:
Date:

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Patient Name:_____ DOB:_____

Date:_____

Medications

Medication Name:	Dosage:
Medication Name:	Dosage:
Medication Name:	Dosage:
Medication Name:	Dosage:
Medication Name:	Dosage:
Medication Name:	Dosage:
Medication Name:	Dosage:

Allergies

1.
2.
3.
4.
5.

Hospitalizations / Procedures

Procedure:	Year:	Hospital:
Procedure:	Year:	Hospital:
Procedure:	Year:	Hospital:
Procedure:	Year:	Hospital:

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Patient Name:_____ DOB:_____

Date:_____

Current Review of Systems

Please select all symptoms that apply and write in any additional.

GENERAL: □ Weight loss or gain □ Fatigue □ Fever or chills □ Trouble sleeping □ Weakness	**GASTROINTESTINAL:** □ Swallowing difficulties □ Heartburn □ Nausea/vomiting □ Blood in stool □ Dark/tarry stools
SKIN: □ Rashes □ Itching	**URINARY:** □ Painful urination □ Hematuria □ Frequent urination at night
EYES: □ Pain □ Sudden vision changes **EARS:** □ Ringing in the ears □ Earache	**MUSCULOSKELETAL:** □ Joint pain □ Back pain □ Muscle pain
NECK: □ Lumps □ Swollen glands □ Pain	**NEUROLOGICAL:** □ Fainting □ Seizures □ Weakness □ Headaches
RESPIRATORY: □ Cough □ Productive cough □ Coughing up blood	**HEMATOLOGIC:** □ Ease of bleeding □ Ease of bruising □ History of blood clots
VASCULAR: □ Swelling □ Varicose veins (bulging, bluish veins) □ Pain in legs when walking □ Ulcers or sores on legs or feet □ Skin discoloration on legs	**CARDIOVASCULAR:** □ Chest pain/discomfort □ Palpitations □ Swelling □ Shortness of breath □ Pain when breathing while lying flat

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Date:_____

Past Medical History

Please check all that apply.

HEAD: □ Trauma **EYES:** □ Blindness □ Cataracts □ Glaucoma □ Wear glasses/contacts **EARS:** □ Hearing aids	**CARDIOVASCULAR:** □ Aneurysm □ Angina □ DVT □ Dysrhythmia □ Hypertension □ Murmur □ Myocardial infarction □ Other heart disease	**RESPIRATORY:** □ Asthma □ Bronchitis □ COPD □ Bronchitis □ Emphysema □ Pleuritis □ Pneumonia
NOSE/SINUSES: □ Allergic rhinitis □ Sinus infections **MOUTH/THROAT/TEETH:** □ Dentures	**SKIN** □ Dermatitis □ Mole(s) □ Psoriasis □ Other skin condition(s)	**INFECTIOUS** □ HIV □ STIs □ Tuberculosis (disease) □ Tuberculosis (exposure)
GASTROINTESTINAL □ Cirrhosis □ GERD □ Gallbladder disease □ Heartburn □ Hemorrhoids □ Hepatitis □ Hiatal hernia □ Jaundice □ Ulcer	**GENITO-URINARY** □ Hernia □ Incontinence □ Nephrolithiasis □ Other kidney disease □ STIs □ UTIs **HEME/ONC:** □ Anemia □ Cancer	**ENDOCRINE** □ Goiter □ Hyperlipidemia □ Hyperthyroidism □ Thyroid disease □ Thyroiditis □ Type I DM □ Type II DM
PSYCHIATRIC □ Bipolar disorder □ Depression □ Hallucinations, delusions □ Suicidal ideation □ Suicidal attempts	**MUSCULOSKELETAL** □ Arthritis □ Gout □ Musculoskeletal injury	**NEUROLOGICAL** □ Epilepsy □ Seizures □ Severe headaches/migraines □ Stroke □ TIA(s)