FLORIDA ELECTROPHYSIOLOGY ASSOCIATES®

Robert S. Fishel, MD, FACC
Faren R. Angella, MD, FACC
Vlad Rankovic, MD, FACC
Marcelo A. Jimenez. MD. FHRS
Matthew J. Kolek, MD, MSc
Jason M. Appelbaum, MD.
Alejandro J. Restrepo, MD, FHRS, FRACP

Rajesh Harrilal, APRN
Lindsey Sarja, APRN
Wislande Gillis, APRN
Lina Mosquera-Rosales, APRN
Aleksandrs Morozovs, APRN
Valonie Richardson, APRN
Amanda Bayerlein, APRN

PATIENT INFORMATION

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Name:

Address:

Best Contact Number: Can we text this number: ◯ Yes ◯ No

DOB: Last 4 Digit SSN: Email Address:

Marital Status: ◯ Married ◯ Divorced ◯ Single ◯ Widowed

INSURANCE ***This information will be scanned in at the time of your appointment***

DO YOU HAVE AN EXISTING IMPLANT, IF SO PLEASE SELECT MANUFACTURER

◯ Medtronic ◯ St Jude ◯ Boston Scientific ◯ Biotronik

HOSPITALIZATION INFORMATION

When was the last time you were hospitalized:

What facility:

Hospitalization information is important so we can have the most up to date important medical records for your appointment

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MEDICATION LOG

PATIENT INFORMATION

Name:

Phone Number: DOB:

Email Address:

Pharmacy Name: Pharmacy Number:

Allergies:**

MEDICATIONS	DOSAGE	QUANITITY	FREQUENCY

180 JFK Drive, Ste 311
Atlantis, FL 33462

1004 S. Old Dixie Hwy., Ste 201
Jupiter, FL 33458

1715 SE Tiffany Ave., Ste A
Port St. Lucie, FL 34958

10151 Enterprise Ctr. Blvd., Ste 202
Boyton Beach, FL 33437

Phone 561.434.0353 **Fax** 561.357.0869 **Toll Free** 888.VTACH.MD heartbeatdoctor.com

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PATIENT MEDICAL HISTORY QUESTIONNAIRE

DO YOU HAVE ANY OF THESE MEDICAL PROBLEMS?

◯ Diabetes	◯ High Blood Pressure	◯ Prior Heart Attack	◯ Stroke
◯ Angina (chest pain)	◯ Ulcer	◯ Bleeding Disorder	◯ Kidney Disease
◯ Liver Disease	◯ Thyroid Disorder	◯ Cancer	◯ Lung Problems

Other:

SURGERY

◯ CABG (Coronary Bypass)	◯ Valve Replacement	◯ Defibrillator	◯ Pacemaker
◯ Gall Bladder	◯ Tonsillectomy	◯ Appendectomy	◯ Hernia

Other:

PLEASE PROVIDE:

Have you smoked: ◯ No ◯ Yes Packs/Day: # Years : If you quit, When?

Alcohol Intake: ◯ No ◯ Yes Typical amount and frequency:

Recreational Drug Use: ◯ No ◯ Yes Typical amount and frequency:

FAMILY HISTORY

Father: ◯ Alive, age or ◯ Deceased at age From:

Mother: ◯ Alive, age or ◯ Deceased at age From:

# of Brothers and any illiness:

# of Sisters and any illiness:

and ages of Children and any illinesses:

Is there a family history of: ◯ Heart Attack ◯ Bypass Surgery ◯ Cardiac Arrest ◯ Serious Rhythm Problems

◯ Unexplained Fainting ◯ Other

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PLEASE CHECK ALL THAT APPLY

GENERAL

- ◯ Fevers
- ◯ Chills, Shakes
- ◯ Rashes
- ◯ Swollen Glandes
- ◯ Frequent Itchiness
- ◯ Significant Intolerance to Heat/Cold

EYES

- ◯ Blurred Vision
- ◯ Double Vision
- ◯ Cataracts
- ◯ Glaucoma

EARS

- ◯ Diminished Hearing
- ◯ Tinnitues (Riniging, Buzzzing)
- ◯ Deafness

MOUTH

- ◯ Poor Dentition
- ◯ Dentures
- ◯ Gum Bleeding

NEUROLOGIC

- ◯ Significant Memory Loss
- ◯ Arm or Leg Weakness
- ◯ Unsteady Gait (Walking)
- ◯ Speech Difficulty
- ◯ Visual Disturbances

UROLOGIC

- ◯ Burning on Urination
- ◯ Blood in Urine
- ◯ Very Frequent Urination

JOINTS

- ◯ Swelling
- ◯ Stiffness
- ◯ Unusual Warmth

MEMNTAL HEAL

- ◯ History of Major Depression
- ◯ Severe Anxiety

EXTREMITIES

- ◯ Leg Pain While Walking
- ◯ Varicose Veins
- ◯ Swelling

CARDIAC

- ◯ Chest Pains
- ◯ Shortness of Breath
- ◯ Palpitations
- ◯ Dizzy Spells
- ◯ Fainting Spells
- ◯ Wake Up Gasping for Air

LUNGS

- ◯ Cough
- ◯ Wheezing
- ◯ Pain with Deep Breathing

GASTROINTESTION

- ◯ Nausea
- ◯ Vomiting
- ◯ Bright Blood in Stool
- ◯ Black / Very Dark Stool
- ◯ Poor Appetite
- ◯ Costipation
- ◯ Significant Weight Loss
- ◯ Acid Reflux

SKIN

- ◯ Fevers
- ◯ Chills, Shakes
- ◯ Rashes

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RECORDS RELEASE FORM

To: _____

_____

_____

Patient Name _____

DOB _____

Last 4 Digits SSN _____

Dear Doctor:

Please be so kind as to send the following records on the above patient:

_____ All records: Cardiac catheterizations, holter and/or event monitor reports with strips, most recent EKG, any pacemaker/defibrillator information, ECHO reports, Stress test: two parts, most recent office note.

Please fax this page back with records.

Thanks for your help.

Any medical records pertaining to me may be sent to Florida Electrophysiology Associates, PA at the above below.

Dr. Fishel 561-983-6171

Dr. Angella 561-983-6171

Dr. Rankovic 561-983-6171

Dr. Marcelo Jimenez 561-948-2817

Dr. Kolek 561-983-6171

Dr. Appelbaum 561-983-6165

Dr. Alejandro J. Restrepo 772-353-5801

Signed: _____

Date: _____

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HIPAA RELEASE FORM

Name_____ Date of Birth: _____/_____/_____

We may release your health information, including information about your condition, to a family member or friend who may be involved in your medical care or who helps you pay for your care. As described in our Notice of Privacy Practices, you have the right to request that we do not release your health information to certain individuals.

Please use the form below to indicate with whom we may release your health information to, notify or assist in the notification of a family member or friend who may be involved in your care.

Release of information

I authorize the release of information including the diagnosis, records, examination rendered to be and claims information. This information may be released to:

Spouse: _____

Child(ren): _____

Other: _____

This HIPAA release will remain in effect until terminated by me in writing. **When leaving a message:**

Please Call:

If unable to reach me:

You may leave me a detailed message:

You may leave a message asking me to return you call:

The best day to reach me is:_____ Between: _____-_____ And _____:_____

Signed:_____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

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CANCELLATION / NO SHOW POLICY

For Doctor Appointments and Surgery

1. Cancellation / No Show Policy for Doctor Appointments:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel and appointment, you may be preventing another patient from getting the much needed treatment they need. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full schedule”.

If an appointment is not canceled at least 24 hours in advance you will be charged a one-hundred-dollar : ($100.00) fee; this will not be covered by your insurance company.

2. Account Balance:

We will require that patients with self-pay balances due, pay their account balances to zero (0) prior to receiving further services by our practice. Patients Who have questions about their bill or who would like to discuss a payment plan option may call and ask to speak with the office manager with whom they can review their account and concerns.

Patients with balances over one hundred dollars ($100) must make payment arrangements prior to future appointments being made.

Print Patient Name: _____ Signature:_____

Date: _____/_____/_____ Pateint Account # (office use only): _____