Dr. Carlos M Alves M.D.

PATIENT REGISTRATION FORM

Name _____ SS # _____

Street Address _____ Date of Birth _____ Gender: M F Marital Status: S M W D

City _____ State _____ Zip _____

Telephone: Home _____ Office _____

Mobile _____ Email _____

Spouse's name _____

PATIENT EMPLOYER INFORMATION

Emloyer name _____ Tel. # _____

Employer street adress _____ City / State _____ Zip _____

Patient's occupation _____

INSURED PERSON (IF NOT PATIENT)

Name _____ Tel. # _____ Date of Birth: _____

Street adress _____ City / State _____ Zip _____

Relationship to patient _____

INSURANCE

Medicare # (if applicable) _____

Primary Insurance Company Name _____

ID# _____ Group # _____ Tel. # _____

Secondary Insurance Company Name _____

ID# _____ Group # _____ Tel. # _____

Medicare requires that we ask you the following questions, thank you for your cooperation:

Preferred Language:	Race (Physical characteristics):		Ethnicity (Social groups / Shared History):
( ) English	( ) American Indian	( ) Asian	( ) Not Hispanic or Latino
( ) Spanish	( ) Black	( ) White	( ) Hispanic or Latino
( ) Other:	( ) Race disclosure declined by patient.		( ) Ethnicity discolsure declined by patient.

INFORMATION AND ASSIGNMENT OF BENEFITS

EMERGENCY CONTACT INFORMATION

Name of Person: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone No: _____

Work Phone No: _____

RELEASE OF MEDICAL INFORMATION: I authorize the release of any medical information necessary for care or treatment as well as to process this insurance claim.

Signature of responsible party: _____ Date: _____

PAYMENT OF BENEFITS ASSIGNMENT: I hereby authorize my insurance benefits to be paid directly to CONEJO VALLEY ELECTRO-PHYSIOLOGY, INC. I understand that I have full repsonsibility for all professional services rendered and will remit appropriate co-payment or charges at time of service.

Signature of responsible party: _____ Date: _____

Dr. Carlos M Alves M.D.
865 Patriot Drive, Suit 201
Moorpark, CA 93021
(805) 768-4198 (805) 553-9835 fax

PATIENT CONSENT FORM

The Department of Health of Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entitites are most often required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objetions to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identifie as a national problem causing patients incovenience, aggravation, and money. We want you to know that all of your employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountablity Act (HIPAA) with particular emphasis on the “Privacy Rule”. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromised our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Dr. Carlos M Alves M.D.

DATE: _____

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PATIENT HISTORY FORM

NAME: BIRTHDATE: EMAIL:

CURRENT MEDS

Medication	Dose	How often

CHRONIC MEDICAL PROBLEMS

ACUTE MEDICAL PROBLEMS

DRUG ALLERGIES — TYPE OF REACTION

FOOD ALLERGIES

SOCIAL HISTORY

Smoking Status:

- ☐ Never Smoker
- ☐ Former Smoker
- ☐ Less than 1 pack/day
- ☐ More than 1 pack/day

Coffee: Cups daily _____

Other caffeine _____

Alcohol: Drinks per week _____

Recreational Drugs: _____

Martial Status: S M W D SEP

Number of Children _____

Pregnancies ___ Abortions ___ Miscarries ___ Live Births ____

Occupation _____

SURGERIES

Reason	Date

FAMILY MEDICAL HISTORY

Father: _____

Mother: _____

Father's Parents: _____

Mother's Parents: _____

Siblings: _____

Children: _____

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CONFIDENTIAL QUESTIONNAIRE

Name, Last _____ First _____

Describe briefly the reason you were referred to or are seeking the services of an Electrophysiologist.

Symptoms: _____

_____

_____

Do you have chest pain? Yes: _____ No: _____ in the past, yes: _____

If yes, what brings on the chest pain? _____

Where is the chest pain located? _____

How long does it last? _____ Is it aggravated by meals? _____

Does the pain go into the shoulder, arm or neck? Yes _____ No _____

Does exercise cause the pain? Yes _____ No _____

Does emotional stress make the pain worse? Yes _____ No _____

Do you notice palpations or heart racing? Yes _____ No _____

Is dizziness a common problem? Yes _____ No _____

Do you have shortness of breath when you are not exerting yourself? Yes _____ No _____

Do you have foot or ankle swelling? Yes _____ No _____

Have you ever been told you have a heart murmur? Yes _____ No _____

Do you have leg cramps when walking? Yes _____ No _____

Have you been told by a physician you have diabetes? Yes _____ No _____

Have you been told of an elevated “cholesterol or triglyceride level”? Yes _____ No _____

Cholesterol level? _____ Triglyceride level? _____

Do you smoke? Yes _____ No _____ if yes, how many a day _____ , age when started _____

If no, did you smoke in the past? Yes _____ No _____ how much? _____ age stopped _____

Do you consider your job to be “high pressure”? Yes _____ No _____

Do you exercise regularly? Yes _____ No _____ Type of activity _____

Do you currently have or ever had cancer? Yes _____ No _____ Type _____