

Name: _____ Date: _____

Describe the present problem that brings you to this office. Please be specific with symptoms.

Family History: (check/answer all that apply)

	Heart disease	High blood pressure	Diabetes	High cholesterol	Stroke	Peripheral vascular disease
Father	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Mother	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Brother(s)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Sister(s)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Self	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Review of systems: (Please check all that apply)

Yes	No	<u>Constitutional</u>		Yes	No	<u>Musculoskeletal</u>
Yes	No	Trouble sleeping		Yes	No	Difficulty walking
Yes	No	Lack of energy		Yes	No	Joint pain/swelling
Yes	No	Appetite changes		Yes	No	Back Pain
Yes	No	Thyroid problems				<u>Skin</u>
Yes	No	Fevers/frequent infections		Yes	No	Non-healing sores
		<u>HEENT</u>				<u>Gastrointestinal</u>
Yes	No	Serious eye problems		Yes	No	Liver problems
Yes	No	Hearing problems		Yes	No	Nausea/vomiting
Yes	No	Nose problems		Yes	No	Heartburn
Yes	No	Throat problems		Yes	No	Constipation
		<u>Cardiac</u>		Yes	No	Blood in stool
Yes	No	Chest pain		Yes	No	Diarrhea
Yes	No	Heart rhythm problems		Yes	No	Swallowing difficulties
Yes	No	Fainting or blackouts		Yes	No	Abdominal pain
Yes	No	Heart Murmur				<u>Neurological</u>
Yes	No	Swelling		Yes	No	Numbness/Tingling
Yes	No	Leg/buttock pain		Yes	No	Dizziness
		<u>Respiratory</u>		Yes	No	Weakness
Yes	No	Shortness of breath		Yes	No	Seizures
Yes	No	Cough/sputum/phlegm				<u>Genito-Urinary</u>
Yes	No	Wheezing		Yes	No	Recurrent urinary tract infection
Yes	No	Chronic lung disease		Yes	No	Frequent urination at night
		<u>Hematological</u>		Yes	No	Difficult urination
Yes	No	Bleeding disorders		Yes	No	Prostate problems
Yes	No	Anemia		Yes	No	Kidney stones
Yes	No	Blood clots		Yes	No	Pregnancy
				Yes	No	Loss of bladder control
				Yes	No	Kidney Problems

Past Medical History: _____



CODE STATUS

Name: _____
Birth Date: _____
Today's Date: _____
MRN #: _____

Date Updated: _____

Wishes the Same? Y or N _____

I WISH TO BE:

(circle one of the following)

1. FULL CODE (Includes CPR)

2. CODE WITH LIMITATIONS:

- a. No Intubation
- b. No Pacemaker
- c. No Defibrillation
- d. No Hemodialysis
- e. No Catheterization

3. DO NOT RESUSCITATE (Do NOT Perform CPR)

I hereby certify that I have read this document or it was read to me, that I fully understand the above, and that these are my wishes.

Patient Signature

Date

Witness To Signature

Date

GUARDIANS:

I, _____, hereby certify that I am the _____
Of the patient, that the patient is unable to consent because the patient is a minor or because
_____.

Patient Signature

Date

Witness To Signature

Date

**CONSENT TO DISCLOSURE RELEASE AND EXCHANGE
OF HEALTH/TREATMENT INFORMATION AND RECORDS**
(Allows us to get information from other Doctors & Hospitals)

Patient/Client Name:

Birth Date:

X

X

Authorize:

Its designee or record department, to release information contained in my medical records to the individual or organization named below:

Name

The Heart + Wellness Institute, Dr. Prerana Manohar

Address:

5043 Cascade Road SE
Grand Rapids, MI 49546

Phone: (616) 719-5939
Fax: (616) 719-5933

The following information from my health/treatment records may be disclosed:

Entire chart	Date of service
Physician orders	Lab results
Operative notes	X-Rays
Progress notes	Other
History and Physical	Other

I understand;

1. That disclosure may include information regarding diagnosis and treatment for substance abuse, psychiatric illness and/or psychologist and social worker contacts if they did occur, it may also include information regarding HIV, AIDS and ARC.
2. That this authorization may be withdrawn by me at any time, revocation of this authorization will not affect any information already released.
3. That a photocopy of this consent shall be treated the same as the original.
4. As part of our ongoing quality assurance, your records may be selected for peer review.

Patient/Authorized Person

Date

X

If signed by other than patient

Relationship of party signing

Patient is unable to consent because:

Minor, _____ years of age

Other (please specify) _____

Witness

Date

PERSONAL:

Name: First: _____ Middle: _____ Last: _____

Preferred Name: _____ Birthdate: _____ SS#: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Cell/Other: _____

E-Mail Address: _____

By providing your e-mail address, you elect to receive e-mail communications from The Heart + Wellness Institute

Work Company Name: _____

Work Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Ext: _____

INSURANCE:

Primary Insurance: _____ Secondary Insurance: _____

Primary Insured Name: _____ Primary Insured Name: _____

Birthdate: _____ SS#: _____ Birthdate: _____ SS#: _____

Relationship to Patient: _____ Relationship to Patient: _____

CONSENT TO DISCLOSE:

Emergency Contact Person Name: _____ Phone: _____

I also give The Heart + Wellness Institute consent to disclose my personal information to the following People:

PHYSICIANS* and PHARMACY:

Referring Physician: _____ Phone: _____

Primary Physician: _____ Phone: _____

Other Physician: _____ Phone: _____

*By providing these physician names, you are allowing us to communicate with these physicians regarding your continued care.

Preferred Pharmacy: _____ Phone: _____

Address/Location : _____

ALLERGIES: Please list allergies with reaction

ACKNOWLEDGEMENTS:

- I acknowledge that the above information provided is accurate to the best of my knowledge and ability.
- I acknowledge it is my responsibility to update this information with The Heart + Wellness Institute if any of it were to change.
- I acknowledge that I have received the Notice of Privacy Practices / HIPPA and have been provided an opportunity to review it and keep a copy for my personal records.
- I assign directly to The Heart + Wellness Institute all insurance benefits for services rendered.
- I understand and acknowledge that my insurance coverage is a contract between me and my insurance company therefore I am responsible for my account and agree to pay any deductible, coinsurance, co-pay, as well as any other non-covered charges within 60 days unless previously agreed upon by The Heart + Wellness Institute.
- I understand I am financially responsible for all charges from The Heart + Wellness Institute whether or not paid by my insurance.
- I authorize my signature on all insurance submissions.
- I request payment of authorized Medicare and Medigap benefits be made to The Heart + Wellness Institute for any services rendered.

Printed Name: _____ Birthdate: _____

Signature: _____ Date: _____