

THE HEART CENTER OF NORTH TEXAS, P.A.

1017 12th Avenue, Fort Worth, TX

941 Hilltop, Weatherford, TX

Acknowledgement of Receipt of Notice of Privacy Practices

I. I have been informed and received a copy of the *Notice of Privacy Practices for the Heart Center of North Texas*. The Heart Center of North Texas reserves the right to modify the privacy practices outlined in the notice.

II. I authorize the Heart Center of North Texas staff to leave telephone messages regarding my appointments, test/results, and general care at the following designated telephone numbers in the event that I am unavailable to personally take the call. I reserve the right to change this information at any time.

Telephone Numbers: _____

Telephone Numbers: _____

III. Disclosure of Information to Relatives or Other Designated Persons

The following individuals are people that I would like to be involved in or have access to my protected health information on a routine basis. I authorize for the Heart Center of North Texas, P.A. to share my protected health information with:

Name Relationship Phone #

Name Relationship Phone #

Name Relationship Phone #

Patient Name: _____ Date of Birth: ___/___/___

Social Security #: _____

Patient Signature or Patient Representative Signature

Date

Relationship to Patient (required if patient is a minor or an adult who is unable to sign this form.)

Patient Name: _____

Date: _____

Cardiologist: _____

Primary Care: _____

Heart Center of North Texas Quick Review of Systems

Your Physician would like for you to take a moment to mark whether you *have* or *have not* had any of these symptoms since your last visit. Thank you

		Y	N	Explain
Cardiac:	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	
	Irregular/fast heart beat	<input type="checkbox"/>	<input type="checkbox"/>	
	Sweating	<input type="checkbox"/>	<input type="checkbox"/>	
	Passing out	<input type="checkbox"/>	<input type="checkbox"/>	
	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	
	Difficult breathing @ night	<input type="checkbox"/>	<input type="checkbox"/>	
Vascular:	Leg pain with walking	<input type="checkbox"/>	<input type="checkbox"/>	
	Swollen feet/ankles	<input type="checkbox"/>	<input type="checkbox"/>	
Body related:	Weight gain _____ lbs	<input type="checkbox"/>	<input type="checkbox"/>	
	Weight loss _____ lbs	<input type="checkbox"/>	<input type="checkbox"/>	
	Unexplained fever	<input type="checkbox"/>	<input type="checkbox"/>	
Head/eyes/ears/nose/	Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	
throat:	Hearing loss, nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs:	Snoring, cough with blood	<input type="checkbox"/>	<input type="checkbox"/>	
	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach:	Nausea, bleeding or reflux	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary:	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
	Frequent urination @ night	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological:	Dizzy, Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	
	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric:	Depression Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	
Blood disorders:	Severe Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
	Low Platelets	<input type="checkbox"/>	<input type="checkbox"/>	
	Bruising, bleeding, clots	<input type="checkbox"/>	<input type="checkbox"/>	
	History of Oral Contraceptive	<input type="checkbox"/>	<input type="checkbox"/>	
Reproductive:	Erectile Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine:	Thyroid Goiter	<input type="checkbox"/>	<input type="checkbox"/>	
	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	
Skin:	Rash, skin sores	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal:	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	
	Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>	
Other:				