FORT BEND HEART CENTER

Patient Registration Form

Last Name: ______________________ First Name: ______________________ MI: ______

Sex: Male ______ Female ______ Date of Birth: ______________ SSN: ______-_____-______

Marital Status: Single ______ Married ______ Divorced ______ Widowed ______ Separated ______

Address: ____

City: ________________ State ________________ ZIP code: ________________

Home Ph.# ________________ Cell Ph. # ________________ Work Ph. # ________________

E-Mail Address: ________________ Referred By: ____________________________

Language: ________________ Race: ______________, Ethnicity: ________________

Spouse's Name: __________________________ Spouse's Contact # ________________

Emergency Contact: __________________________ Ph. # ________________________

Employer Information

Employer Name: __________________________ Ph.# ________________________

Employer Address: ____

City: ________________ State: ________________ Zip code: ________________

Patient's Occupation: ____

INSURANCE INFORMATION

Primary Insurance Company: __________________________ PH. # ________________

Policy #: __________________________ Group # ______________________________

Secondary Insurance Company: ________________________ Ph. # ________________

Policy #: __________________________ Group # ______________________________

Patient Signature: __________________________ Today Date: ____________________

FORT BEND HEART CENTER

Please respond to the following questions by placing a check mark ( ) or write the correct answer.

Patient Social History

Tobacco Smoking Status: _____ Never, ______Former, ______Every Day, ______ Someday.

Smoking- How Much: _______ Per Day, ______ Per Week,

Tobacco- Years of Use: ______

Smokeless Tobacco Status: ______ Never, ______Former, ______Every Day, ______ Someday.

Chewing Tobacco: ______ Never, ______Former, ______Every Day, ______ Someday.

E-Cigarette/Vape Status: ______ Never, ______Former, ______Every Day, ______ Someday.

Has Smoked Since Age: _______

Alcohol Intake: ______None, _____Occasional, ______ Moderate, ______ Heavy.

Alcohol Years of Intake: ________

Illicit Drugs: ______None, _____Occasional, ______ Moderate, ______ Heavy

Caffeine Intake: ______None, _____Occasional, ______ Moderate, ______ Heavy.

Live Alone or With Other: ______ Alone, ______ With Others.

Number of Children: _________

General Stress Level: ______ Low, ______Medium, ______High.

Diet: __ Regular, __Vegetarian, __ Vegan, __ Gluten Free, ___Cardiac, ___Carbohydrate, __Low Sodium ____

Exercise Level: ______None, _____Occasional, ______ Moderate, ______ Heavy

FAMILY HISTORY

Is your Father? Alive (Age ____) Deceased (Age ____), Unknown

Health Problem if any?: ________________________________, Unknown

Is your Mother? Alive (Age ____), Deceased (Age ____), Unknown

Health Problem if any?: ________________________________ Unknown

Patient name: ___________________________ ***Date:*** ___________________

Signature: ___________________________

FORT BEND HEART CENTER

Have you ever had any of the following?

1. Abnormal Chest X-Ray	Yes No
2. Abnormal EKG	Yes No
3. Anxiety, Depression or Mental Illness	Yes No
4. Blood Problems (Abnormal Bleeding, Anemia, High or Low White Count).	Yes No
5. Diabetes.	Yes No
6. Heart Valves or Abnormal Heart Rhythm.	Yes No
7. High Blood Pressure.	Yes No
8. High Cholesterol or Triglycerides	Yes No
9. Sexually Transmitted Disease	Yes No
10. Stroke or TIA	Yes No
11. Treatment for Alcohol And/or Drug Abuse	Yes No
12. Tuberculosis or Positive Tuberculin Skin Test	Yes No
13. Thyroid or Parathyroid Glands	Yes No
14. Coronary (Heart) Arteries (Angina).	Yes No
15. Arteries Surgery (Aorta, Arteries to Head, Arms, Legs).	Yes No
16. Veins or Blood Clots in The Veins.	Yes No
17. Palpitations	Yes No
18. Syncope ('Blackouts', 'Faints', 'Collapse') Or Dizziness.	Yes No
19. Angioplasty and Atherectomy Or PCI (Percutaneous Coronary Intervention).	Yes No
20. Stent Procedure.	Yes No
21. A Coronary Artery Bypass Graft (CABG).	Yes No
22. Heart Valve Replacement Surgery).	Yes No
23. Cardiomyopathy.	Yes No
24. Pacemaker.	Yes No
25. Warfarin or Coumadin Management.	Yes No
26. Snoring	Yes No
27. Numbness	Yes No

Patient name: ______________________ Date: ____________________

Signature: ______________________

FORT BEND HEART CENTER

SURGICAL HISTORY

		When?
Knee Surgery	Yes No	________
Cholecystectomy	Yes No	________
Colonoscopy	Yes No	________
Eye Surgery	Yes No	________
Gastrointestinal Surgery	Yes No	________
Hernia Repair	Yes No	________
Hysterectomy	Yes No	________
Orthopedic Surgery	Yes No	________
Prostate Surgery	Yes No	________
Thyroid Surgery	Yes No	________
Tonsillectomy/Adenoidectomy	Yes No	________
Vascular Surgery	Yes No	________
Abdominal Surgery	Yes No	________
Appendectomy	Yes No	________
Back Surgery	Yes No	________
Breast Surgery	Yes No	________
Caesarean Section	Yes No	________
Cardiac Catheterization	Yes No	________
Others	Yes No **Specify** ______	

Patient name: ______________ Signature: ________________

Date: ____________________

FORT BEND HEART CENTER

INFORMATION AND ASSIGNMENT OF BENEFITS

I______________________________ authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in place of the original.

Signature: __________________________ **Date:** __________________________

I hereby authorize Dr. Naim Al-Adli to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance company be made directly to Dr. Naim Al-Adli (or to the party who accepts assignment).

I certify that the information I have reported regarding my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

Signature: __________________________ *Date:* ____________________

FORT BEND HEART CENTER

13020 Dairy Ashford Rd. Ste. 301
Sugar Land, Tx. 77478

Phone: (281) 265-8500
Fax: (281) 265-8588

RELEASE OF INFORMATION

I hereby authorize ______________________________to furnish medical

Records of ____________________________ covering the periods from

______________________ to _________________.

These records are to be released to **Fort Bend Heart Center.**

I hereby release you, your physician and employees from liability for following tis authorization and request.

______________________________ _______________

PATIENT SIGNATURE **DATE**

______________________________ _______________

WITNESS **DATE**

Fort Bend Heart Center
Vein Screening Questionnaire

Patient Name: ______________________________ Date: ______________

Do you have or have you ever been diagnosed with:

Varicose vein problems	☐ Y ☐ N	Leg: ☐ R	☐ L
Leg or Ankle Ulcers	☐ Y ☐ N	Leg: ☐ R	☐ L
Spider Veins	☐ Y ☐ N	Leg: ☐ R	☐ L

Do you experience any of the following in your leg(s):

Aching/pain	☐ Y ☐ N	Leg: ☐ R	☐ L
Heaviness	☐ Y ☐ N	Leg: ☐ R	☐ L
Tiredness/fatigue	☐ Y ☐ N	Leg: ☐ R	☐ L
Itching/burning	☐ Y ☐ N	Leg: ☐ R	☐ L
Swelling	☐ Y ☐ N	Leg: ☐ R	☐ L
Cramps	☐ Y ☐ N	Leg: ☐ R	☐ L
Restless legs	☐ Y ☐ N	Leg: ☐ R	☐ L
Throbbing	☐ Y ☐ N	Leg: ☐ R	☐ L
Skin or ulcer problems	☐ Y ☐ N	Leg: ☐ R	☐ L

Do you do any of the following to improve the discomfort in your leg(s)?

Take Medication for pain ☐ Y ☐ N What? ____________________________

Elevate your legs ☐ Y ☐ N What? ____________________________

Wear support hose ☐ Y ☐ N What? ____________________________

Personal and Family History:

Does anyone in your family have Varicose Veins? ☐ Y ☐ N If so who? ____________________

Have you ever been pregnant? ☐ Y ☐ N If so how many times? _______

Do you sit or stand for long periods of time? ☐ Y ☐ N For how long? _________________

Do you exercise regularly? ☐ Y ☐ N How often? ______________

FORT BEND HEART CENTER

13020 Dairy Ashford Rd. Ste. 301
Sugar Land, TX 77478
Office: (281)-265-8500
Fax: (281)-265-8588

Cancellation/ No Show Policy
For Naim Al-Adli M.D. Appointments & Procedure

1. Cancellation/ No Show Policy for Doctor Appointment

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 an appointment, you may be preventing another patient from getting much needed treatment. 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" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; your insurance company will not cover this.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time. ***If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.***

3. Cancelation/ No Show Policy for Procedure

Due to the large block of time needed for procedure, last minute cancellation can cause problems and added expenses for the office.

If a procedure is not cancelled at least 24hrs in advanced you will be charged a seventy-five dollar ($75) fee; your insurance company will not cover this.

______________________ Print Patient Name

______________________ Patient Signature

__/__/__ Date

Cardiologist ______________________
Naim Al-Adli M.D.

FORT BEND HEART CENTER

NAIM AL- ADLI, M.D.
13020 DAIRY ASHFORD
STE. 301
SUGARLAND, TEXAS 77478

PRIVACY PRACTICES ACKNOWLEDGMENT

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

NAME: ______________________________

DATE OF BIRTH: ______________________________

SIGNATURE: ______________________________

TODAY'S DATE: ______________________________

FORT BEND HEART CENTER

13020 Dairy Ashford Rd. Ste. 301
Sugar Land, TX 77478
281-265-8500

Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine, examination, refraction, testing, Holter Monitors, and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office, both my Medicare ID card and my Secondary ID card, If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/ or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior consent. LLCEA/ PS provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

__________________ ____________________ ________

Patient Print Name Patient Signature Date

____

LLCEA/PS Witness