Tong Liu, M.D, Ph.D., FACC — New Patient Information

Patient information

Name:				**Today's Date:**
Age	**Date of Birth:**	**SSN:**		
Current Address:		**City**	**ST**	**Zip**
Home Phone:		**Business/Cell Phone:**		
E-Mail Address:		**Primary Care Physician:**		
Gender : ____ Male ____Female	**Marital Status** (circle) Single Married Divorced Widow(er)			
Employer:		**Occupation:**		
Race: ☐White ☐ African American ☐Hispanic or Latino ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native				
Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino				
Preferred Language: ☐ English ☐Spanish ☐Mandarin/ Cantonese				

EMERGENCY CONTACT INFORMATION		
Name:	**Relationship to patient:**	**Phone:**

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I do hereby authorize any physician examining and/or treating me to release to any third payor (such as insurance company or government agency) and medical and psychiatric information and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis. I do hereby authorize payment directly to any physician examining or treating me for medical benefits otherwise payable to me for their services, but not to exceed there reasonable and customary charge for these services. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me. I permit a copy of these authorization and assignments to be used in place of the original, which is on file at the physician's office. I agree that should the amount of the insurance benefits be insufficient to be cover the expense that I will be responsible for payment of the difference. I will be responsible for the entire amount due for professional services rendered if the expense is not covered by my policy, or if uninsured.

Patient (Guardian) Signature	**Date:**

3310 S.W. 34th Street Ocala, Florida 34474
330 South Lane Ave., Inverness, FL 34452

Phone: 352-873-4733 **Fax:** 352-873-2406

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Patient Health History

Name: _____

Past Cardiovascular History

Disease/ Condition	YES	NO	Treatment
Angina	YES	NO	
Chest Pain	YES	NO	
Heart Murmur	YES	NO	
Palpitations	YES	NO	
Supraventricular Tachycardia (SVT)	YES	NO	
Atrial Fibrillation	YES	NO	
Pulmonary Embolism	YES	NO	
Loss of Consciousness	YES	NO	
Myocardial Infarction (Heart Attack)	YES	NO	
Heart Disease: Type?	YES	NO	
Heart Failure: Type?	YES	NO	
Rheumatic Fever	YES	NO	
Cardiomyopathy	YES	NO	
Endocarditis	YES	NO	
Coronary Artery Disease	YES	NO	
Peripheral Vascular Disease (PVD)	YES	NO	
Peripheral Arterial Disease (PAD)	YES	NO	
Deep Vein Thrombosis	YES	NO	
Lipid/Cholesterol disorder: Type?	YES	NO	
High Blood Pressure	YES	NO	
Aneurysm: Type?	YES	NO	
Edema	YES	NO	
Stroke/TIA	YES	NO	
Sleep Apnea	YES	NO	
Carotid Artery Disease	YES	NO	
Heart Valve Disease	YES	NO	
Diabetes	YES	NO	
Hypothyroidism	YES	NO	
Coumadin/Warfarin therapy	YES	NO	

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Surgery/Procedure	YES	NO	Date (s)
Pacemaker Implant	YES	NO	
Defibrillator	YES	NO	
Cardioversion	YES	NO	
Ablation: Type?	YES	NO	
Cardiac Catheterization	YES	NO	
Stent(s): Where?	YES	NO	
Coronary Artery Angioplasty	YES	NO	
Bypass Surgery	YES	NO	
Valve Surgery/Repair	YES	NO	
Carotid Endarterectomy	YES	NO	
Carotid artery angioplasty and stenting	YES	NO	

Social History:

☐ Smoke Packs daily _____ How long? _____

☐Alcohol Drinks per week? _____ Type of alcohol? _____

☐Caffeine Intake _____ cups per day

☐Illicit drug use Which Drugs? _____

☐Previous/Current Occupation _____

Family History	YES	NO	WHO?
Heart Failure	YES	NO	
Heart Attack/CAD	YES	NO	
Arrhythmias	YES	NO	
Sudden Death	YES	NO	
Hypertension (High blood pressure)	YES	NO	
High Cholesterol	YES	NO	
Cerebrovascular Accident	YES	NO	
Diabetes	YES	NO	

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Medication List

Patient Name:	Date of Birth:
Allergies to Medication: (list also type of reaction)	

Medication	Dosage	Frequency

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Patient information

Notice of Privacy Practices and Authorization Form

Today's Date: _____

I (please print) _____
acknowledge that I have received a copy of Central Florida Heart Center's Notice of Privacy Practices.

In the event that a copy of my personal health information is needed for reasons other than the immediate treatment, I hereby authorize the following family members or friends, acting on my behalf, the release of personal health information to them.

Name: _____
Relationship: _____

Name: _____
Relationship: _____

Name: _____
Relationship: _____

I understand that I may amend this authorization at any time.

I also understand that any other requests for personal health information by anyone else other than those listed above will require additional authorization by myself in writing.

Patient's Signature: _____

Witness: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____
PHONE NUMBER: _____ **SOCIAL SECURITY #:** _____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____ **Date:** _____

The information you may release subject to this signed release form is as follows:

☐ Complete Records ☐ History & Physical ☐ Progress Notes ☐Care Plan
☐ Lab results ☐ Radiology Reports ☐ Other (please specify below)

_____
_____
_____

Release my protected health information to the following physician/person/facility/entity:

Name: Tong Liu, M.D. Ph.D., FACC
Address: 3310 S.W 34th Street Ocala, FL 34474
Phone: 352-873-4733
Fax: 352-873-2406

The purpose/reason for the release of information is as follows:

_____

This authorization is subject to written revocation at any time except to the extent that action has already been taken in reliance, on the authorization. If no previously revoked, this authorization will terminate six (6) months from the date of this signature.

Patient signature: _____ Date: _____

Witness: _____ Date: _____