6200 Sunset Drive, Suite #401
South Miami, Florida 33143

Date: .....

Social Security: .....

Patient Name: ..... Date of Birth: .....

Address: .....

City : ..... State: ..... Zip : .....

Home Phone: ..... . Cell : .....

Male : ..... . Female: .....

Usual Provider: ..... Referring Physician: .....

Married : ..... Single : ..... Divorced : ..... Widowed : ..... Separated: .....

Student: ..... Full Time : ..... Part -Time : ..... Not a Student .....

Employer: ..... Work Phone: .....

.....

Emergency Contact .....

Telephone Number: ..... Relation Ship: .....

.....

ACCOUNT INFORMATION

Subscriber : ..... Self : ..... Spouse: ..... Other: .....

Name: .....

Address : .....

City : ..... State: ..... Zip : .....

Telephone Number: .....

Date of Birth: .....

Social Security Number : .....

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PRIMARY INSURANCE

Name: .....

Address: .....

Policy Number: .....

Group Number: .....

Effective Date: .....

Telephone Number: .....

SECONDARY INSURANCE

Name: .....

Address: .....

Policy Number: .....

Group Number: .....

Effective Date: .....

Telephone Number: .....

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RELEASE AND ASSIGNMENT: I hereby authorize South Miami Heart Specialists to release to my insurance company or its representatives any information, including the diagnosis and the records of any treatment or examination rendered to me during such medical or surgical care. I also authorize my insurance company to pay directly to South Miami Heart Specialists and allowances for medical care.

....
Witness Signature of Insured

.....
Signature of Patient

MECIGAP ASSIGNMENT: I request that payment of authorized MEDIGAP benefits be made on my behalf to South Miami Heart Specialists for any services furnished to me by South Miami Heart Specialists I authorize any holder of medical information about me to release to

.....
any information needed to determine these benefits payable for related services.

....
Witness Signature of Insured

.....
Signature of Patient

I, the undersigned patient, understand that I will be financially responsible for any and all services ordered and/or performed by my attending physician.

In the event that these services are provided and not covered by my insurance plan, including Medicare, I hereby consent to have these services performed and agree for these services.

....
Signature of Patient/ Date
Responsible Party

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PATIENT'S PERSONAL HISTORY

Patient No: .....
Date : .....

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name:	First	Middle	Birth Date	Birth Place

Address:	City:	State:	Zip:	Home Phone	Business Phone

Occupation:	Medicare No.	Medicaid No.

Insurance Company	Insurance No.

Sex		Marital Status								Religion
M	F	S	M	W	D	Separated	A	C	J	P

Person to Notify : ..... Relationship: .....

Address: .....Phone Number .....

Date of Last Physical Examination : ..... Doctor : .....

Family or Referring Physician : .....Address: .....

FAMIL Y HISTORY	If Living		If Deceased	
	Age	Health	Age of Death	Cause
Father				
Mother				
Brothers or Sisters				
Husband or Wife				
Sons or Daughters				

Do you know of any blood relative who has or had:

Stroke..... Epilepsy ..... HeartAttack ..... Nervous breakdown.....

Cancer..... Suicide ..... Stomach ulcers..... Migraine.....

High blood Pressure..... Asthma ..... Kidney disease..... Rheumatic heart.....

Tuberculosis..... Hay fever ..... Goiter ..... Insanity.....

Diabetes..... Arthritis ..... Leukemia..... Bleedingtendency .....

Arthritis Colitis ..... Congenitalheart.....

PERSONAL HABITS:

Yes ☐ No ☐ Do you regularly smoke? Cigarettes ☐ Pipe ☐ Cigars ☐ For how many years?.....

Yes ☐ No ☐ Do you usually drink over 6 cups of coffee per day?

Yes ☐ No ☐ Do you regularly drink alcohol? 1.oz.per day ☐ 2.oz. per day ☐ 4.oz. per day ☐ over6 oz. ☐

BEER: 1.bottle per day ☐ 2.bottles per day over ☐ 4 bottles per day ☐

Yes ☐ No ☐ Do you have difficulty in falling asleep?

Yes ☐ No ☐ Do you awaken early in the morning without apparent cause?

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MEDICATIONS:

Are you presently taking any of the following medications?

Yes ☐	No ☐	Aspirin, bufferin, anacin	Yes ☐	No ☐	Tranquilizers
Yes ☐	No ☐	Blood pressure pills	Yes ☐	No ☐	Weight reducing pills
Yes ☐	No ☐	Cortisone	Yes ☐	No ☐	Blood thinning pills
Yes ☐	No ☐	Cough medicine	Yes ☐	No ☐	Dilantin
Yes ☐	No ☐	Digitalis	Yes ☐	No ☐	Shots
Yes ☐	No ☐	Hormones	Yes ☐	No ☐	Water pills
Yes ☐	No ☐	Insulin or diabetic pills	Yes ☐	No ☐	Antibiotics
Yes ☐	No ☐	Iron or poor blood medications	Yes ☐	No ☐	Barbiturates
Yes ☐	No ☐	Laxatives	Yes ☐	No ☐	Birth control pills
Yes ☐	No ☐	Sleeping pills	Yes ☐	No ☐	Phenobarbital
Yes ☐	No ☐	Thyroid medicine	Yes ☐	No ☐	Other drugs not listed

Please list all your medications

Write in the names and year of any operations which you 'have had:

Name any drugs to which you are allergic:

Write in the names of any diseases you have had which required hospitalization:

Serious Illnesses which you have had: (not requiring hospitalization)

Serious injuries or accidents:

6200 Sunset Drive, Suite #401
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To be answered by WOMEN only:

Yes ☐ No ☐ Are you still having regular monthly menstrual periods?
Yes ☐ No ☐ Have you ever had bleeding between your periods? When? .....
Yes ☐ No ☐ Do you have very heavy bleeding with your periods? When? .....
Yes ☐ No ☐ Do you feel bloated and irritable before your period?
Yes ☐ No ☐ Are you now on or have you ever taken the birth control pill? When? .....
Yes ☐ No ☐ Have you ever had a miscarriage? When? .....
Yes ☐ No ☐ Have you ever had a discharge from the nipple of your breast? When? .....
Yes ☐ No ☐ Do you regularly have the cancer test of the cervix? Date of last test .....

How many children born alive ..... How many miscarriages .....
How many stillbirths ..... How many cesarean operations .....
How many premature births ..... Any complication of pregnancy .....
Date of last menstrual period .....

To be answered by men and women:

Yes ☐ No ☐ Do you frequently have severe headaches? (If yes, answer the following):
Yes ☐ No ☐ Do you have excessive stress or depression?
Yes ☐ No ☐ Do they cause visual trouble?
Yes ☐ No ☐ Do they occur on one side of the head?
Yes ☐ No ☐ Do they awaken you at night from sleep?
Yes ☐ No ☐ Do they feel like a tight hat band?
Yes ☐ No ☐ Do they hurt most in the back of the head and neck?
Yes ☐ No ☐ Does aspirin relieve them?

Yes ☐ No ☐ Have you ever fainted? Yes ☐ No ☐ Have you ever had a convulsion?
Yes ☐ No ☐ Spells of dizziness? Yes ☐ No ☐ Double vision?
Yes ☐ No ☐ Spells of weakness of an arm or leg? Yes ☐ No ☐ Pains in ear?
Yes ☐ No ☐ Ringing in ears? Yes ☐ No ☐ Nosebleeds?

Yes ☐ No ☐ Do you frequently have bleeding gums? Yes ☐ No ☐ Do you frequently have a sore tongue?
Yes ☐ No ☐ Do you frequently have trouble swallowing? Yes ☐ No ☐ Do you frequently have nausea and vomiting?
Yes ☐ No ☐ Do you frequently have hoarseness?

Have you ever had shortness of breath?:

Yes ☐ No ☐ Doing your usual work? Yes ☐ No ☐ Which causes you to cough?
Yes ☐ No ☐ Climbing a flight of stairs? Yes ☐ No ☐ Accompanied by wheezing?
Yes ☐ No ☐ Which awakens you at night? Yes ☐ No ☐ Have you ever coughed blood?
Yes ☐ No ☐ Do you have a chronic cough? Yes ☐ No ☐ Do you cough up much sputum?

Have you ever had chest pain or tightness in the chest which begins when:

Yes ☐ No ☐ When exerting yourself? Yes No Radiates down the arm?
Yes ☐ No ☐ When walking against a wind? Yes No Disappears if you rest?
Yes ☐ No ☐ When walking up hill? Yes No Occurs only at rest?
Yes ☐ No ☐ After a heavy meal? Yes No When walking fast?
Yes ☐ No ☐ When upset or excited? Yes No When walking in cold weather?
Yes ☐ No ☐ Palpitations If you have chest pain or tightness please explain .....
Yes ☐ No ☐ Do you sleep on more than one pillow? .....

Have you recently had pain in the stomach which:

Yes ☐ No ☐ Occurs 1 - 2 hours after a meal?
Yes ☐ No ☐ Is brought on by eating fried foods, gassy foods?
Yes ☐ No ☐ Awakens you at night?
Yes ☐ No ☐ Is relieved by antacid medications?
Yes ☐ No ☐ Is relieved with milk or eating?
Yes ☐ No ☐ Occurs while eating or immediately after?
Yes ☐ No ☐ Is relieved by a bowel movement?
Yes ☐ No ☐ Loss of appetite?

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If you have had change in bowel habit recently answer the following:

When or since when?

Yes ☐ No ☐ Cramp pain in the abdomen?
Yes ☐ No ☐ Alternating diarrhea and constipation?
Yes ☐ No ☐ Pain during or after bowel movement?
Yes ☐ No ☐ Mucous in the stool?
Yes ☐ No ☐ Blood in the stool?
Yes ☐ No ☐ Ribbon-like stools?
Yes ☐ No ☐ Black stools?
Yes ☐ No ☐ Require use of strong laxatives or enemas?

Have you had:

Yes ☐ No ☐ Burning when urinating?
Yes ☐ No ☐ Loss of control of bladder?
Yes ☐ No ☐ Blood in the urine?
Yes ☐ No ☐ Dark colored urine?
Yes ☐ No ☐ Trouble starting to urinate?
Yes ☐ No ☐ Trouble holding the urine?
Yes ☐ No ☐ Getting up frequently at night?
Yes ☐ No ☐ Passed a kidney stone?

Have you recently had:

Yes ☐ No ☐ Pains in calves of legs when walking?
Yes ☐ No ☐ Cramps in legs at night?
Yes ☐ No ☐ Pain in the big toe?
Yes ☐ No ☐ Varicose veins?
Yes ☐ No ☐ Phlebitis or inflamed leg veins?
Yes ☐ No ☐ Swelling in the ankles?

Have you recently had:

Yes ☐ No ☐ Loss of sexual activity? For how long? .....
Yes ☐ No ☐ Treatment for genitals (private parts)?
Yes ☐ No ☐ Dischage from penis?
Yes ☐ No ☐ Hernia (rupture)?
Yes ☐ No ☐ Prostrate trouble?

Describe briefly your present medical symptoms:

6200 SUNSET DRIVE, SUITE 401, SOUTH MIAMI, FLORIDA 33143 (305) 666-4633 • FAX: (305) 665-7498

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Diplomates,
American Board of Cardiovascular Disease
American Board of Internal Medicine

Harry R. Aldrich, M.D., F.A.C.C.
Abbe F. Rosenbaum, M.D, F.A.C.C.
Yale M. Samole, M.D., F.A.C.C.
Bernard S. Silverstein, M.D., F.A.C.C.
Leonard J. Zwerling, M.D., F.A.C.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I ....., have received a copy of this office's Notice of Privacy Practices.

Name: .....

Signature: .....

Date: .....

.....

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

..... Individual refused to Sign

..... Communication barriers prohibited obtaining the acknowledgment

..... An emegency situation prevented us from obtaining acknowledgment

..... Other.....

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTIONA: Patient Giving Consent

Name: .....

Address: .....

Telephone:: ..... Social Security .....

SECTION B: To the Patient - Please read the following statements carefully

Purpose of Consent.By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy PracticesYou have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your. protected health information, and of other important matters about your protected health information.A copy of our Notice accompanies this ConsentWe encourage you to read it carefully before signing this Consent.

We reserve the right to change' our privacy practices as describes in our Notice of Privacy Practices. If we" change our privacy practices, we will issue a revised Notice of Privacy Practices, 'which will contain the changesThose changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Office Administrator .....

Addr ess: 6200 Sunset Drive, Suite 401.Miami, F133143 .....

Telephone: (305) 666-4633 Fax: (305) 662-5754 .....

Right to Revoke You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. ,Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and-that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I ....., have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations,

SIGNATURE: .....**DATE:** .....
