



Circulation Screening

Many people dismiss leg pain as a normal sign of aging. You may think it is arthritis or stiffness from the symptoms, however it may be related to a blockage in your leg preventing adequate circulation. If you are having pain in your legs, please complete the following questions as you may be suffering from a leg circulation condition which is important for your doctor to know about prior to your visit.

1. Do you find you are slowing down when walking or have trouble walking for a certain period of time? YES NO

2. Do you have pain in your hips, thighs, or calves when walking and does the pain stop when you sit for a short period? YES NO

3. Do you have any foot or toe sores or wounds which will not heal quickly? YES NO

4. Do you avoid using stairs or walking up hills because of leg pain? YES NO

5. Do you have any pain in your legs when you sit or rest? YES NO

Name: _____

Date of Birth: _____

Email Address: _____

Thank you for taking time to complete the leg circulation survey. Please return the form to the front desk.

SOUTHERN HEART SPECIALISTS
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Southern Heart Specialists to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Southern Heart Specialists, Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Southern Heart Specialists reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Southern Heart Specialists Privacy Officer at 6507 Professional Pl., Riverdale, GA 30274.

With this consent, Southern Heart Specialists may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Southern Heart Specialists may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Southern Heart Specialists may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Southern Heart Specialists restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to SOUTHERN HEART SPECIALISTS's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, SOUTHERN HEART SPECIALISTS may decline to provide treatment to me.

I give the following people permission to act on my behalf when it pertains to care received from Southern Heart Specialists, P.C. (Including, but not limited to: Test Results, Scheduling appointments, and billing.)

1. _____
2. _____
3. _____

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Patients Name

Date



Southern Heart Specialists, P.C.

Drs. Freireich, Gimbel, Mohan, Mathew, Reddy, Koganti, Dix, Olatidoeye,
Inba-Vazhvu, Mandadi, Wickramasekera, S. Mohan and Lisa Sims, FNP-C

www.southernheart.com

- 6507 Professional Pl. Riverdale, GA 30274 (770) 991-2100
- 1050 Eagles Landing Pkwy. Stockbridge, GA 30281 (770) 474-4248
- 4899 Bill Gardner Pkwy. Locust Grove, GA 30248 (770) 914-0266
- 115 Sumner Rd. Fayetteville, GA 30214 (770) 991-2100

PATIENT INFORMATION

Date: _____ Account #: _____

Name: _____
Last First Middle

Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ Sex: _____ Social Security Number: _____

Employer: _____

Employer Address: _____

Emergency contact name: _____ Emergency phone: _____ Who Referred You? _____

First Insurance Name:

Second Insurance Name:

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Phone: _____ Policy Holder: _____ Phone: _____ Policy Holder: _____

Policy#: _____ Group#: _____ Policy#: _____ Group#: _____

Policy Holder's DOB _____ Policy Holder's DOB _____

Policy Holder's SS# _____ Policy Holder's SS# _____

Name of Husband/Wife: _____

Employed By: _____

Employer Address: _____

Your Occupation: _____

Reason for Consultation: _____

I give my permission for Drs. Freireich, Gimbel, Mohan, Mathew, Reddy, Koganti, Dix, Olatidoeye, Inba-Vazhvu, Mandadi, Wickramasekera, S. Mohan, and Lisa Sims, FNP-C to treat me.

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.

Preferred Method of Payment: Cash Check Credit Card (MC/VISA)

Date (Today)

Signature of Patient/Parent/Responsible Party

I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signed: _____ Date: _____

PATIENT QUESTIONNAIRE

NAME _____ AGE: _____ DATE: _____

HISTORY & PHYSICAL

Please fill out this form as completely as you can. This will help us understand your health problems.

MAJOR COMPLAINT OR REASON FOR VISIT:

ALLERGIES

MEDICATION

REACTION

ARE YOU ALLERGIC TO IODINATED CONTRAST? NO YES
IF YES, WHAT TYPE REACTION DO YOU HAVE? _____

FAMILY HISTORY

FATHER: LIVING AGE: _____
 DECEASED AGE OF DEATH: _____

ANY CARDIAC HISTORY (Heart Attack, Diabetes, Congestive Heart Failure):
IF DECEASED, PLEASE STATE REASON FOR DEATH.

MOTHER: LIVING AGE: _____
 DECEASED AGE OF DEATH: _____

ANY CARDIAC HISTORY (Heart Attack, Diabetes, Congestive Heart Failure)
IF DECEASED, PLEASE STATE REASON FOR DEATH.

ANY OTHER RELATIVES WITH A CARDIAC HISTORY (Brothers, Sisters, Grandparents, etc.)?

RELATIVE CONDITION AGE LIVING OR DECEASED

PAST MEDICAL HISTORY

SURGERIES

TYPE OF SURGERY DATE HOSPITAL SURGEON

ILLNESS

DIAGNOSIS DATE COMPLICATIONS

SOCIAL HISTORY

ALCOHOL YES NO HOW MUCH? _____

ILLEGAL DRUG USE YES NO HOW MUCH? _____

TOBACCO USE YES NO HOW MUCH? _____

EMPLOYMENT:

FULL-TIME PART-TIME SELF-EMPLOYED

DISABLED STUDENT UNEMPLOYED

OTHER (Please specify): _____

EXERCISE:

INACTIVE LIGHT MODERATE HEAVY

LIVING SITUATION:

ALONE WITH SPOUSE WITH PARENTS WITH CAREGIVER

HOSPICE NURSING HOME ASSISTED LIVING

OTHER(Please specify): _____

MEDICATIONS

DRUG NAME STRENGTH # OF PILLS PER DOSE TIMES PER DAY

REVIEW OF SYSTEMS

GENERAL

YES NO

- | | | |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | FATIGUE |
| <input type="checkbox"/> | <input type="checkbox"/> | FEVER |
| <input type="checkbox"/> | <input type="checkbox"/> | NIGHT SWEATS |
| <input type="checkbox"/> | <input type="checkbox"/> | WEIGHT GAIN MORE THAN 10LBS. |
| <input type="checkbox"/> | <input type="checkbox"/> | WEIGHT LOSS MORE THAN 10LBS. |

SKIN

YES NO

- | | | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | EXCESSIVE DRYNESS |
| <input type="checkbox"/> | <input type="checkbox"/> | EXCESSIVE SWEATING |
| <input type="checkbox"/> | <input type="checkbox"/> | NEW HAIR GROWTH |
| <input type="checkbox"/> | <input type="checkbox"/> | NEW HAIR LOSS |
| <input type="checkbox"/> | <input type="checkbox"/> | NAIL CHANGES |
| <input type="checkbox"/> | <input type="checkbox"/> | NEW SORES ON THE SKIN |
| <input type="checkbox"/> | <input type="checkbox"/> | RASH |
| <input type="checkbox"/> | <input type="checkbox"/> | SKIN COLOR CHANGES |

HEENT

YES NO

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | HEADACHE |
| <input type="checkbox"/> | <input type="checkbox"/> | HEAD INJURY |
| <input type="checkbox"/> | <input type="checkbox"/> | COLOR BLINDNESS |
| <input type="checkbox"/> | <input type="checkbox"/> | EXCESSIVE TEARING |
| <input type="checkbox"/> | <input type="checkbox"/> | EYE PAIN |
| <input type="checkbox"/> | <input type="checkbox"/> | EYE REDNESS |
| <input type="checkbox"/> | <input type="checkbox"/> | VISUAL DISTURBANCES |
| <input type="checkbox"/> | <input type="checkbox"/> | VISUAL LOSS |
| <input type="checkbox"/> | <input type="checkbox"/> | DEAFNESS |
| <input type="checkbox"/> | <input type="checkbox"/> | DECREASED HEARING |
| <input type="checkbox"/> | <input type="checkbox"/> | EAR DISCHARGE |
| <input type="checkbox"/> | <input type="checkbox"/> | EAR INFECTION |
| <input type="checkbox"/> | <input type="checkbox"/> | EARACHE |
| <input type="checkbox"/> | <input type="checkbox"/> | RINGING IN EARS |
| <input type="checkbox"/> | <input type="checkbox"/> | VERTIGO/DIZZINESS |
| <input type="checkbox"/> | <input type="checkbox"/> | FREQUENT COLDS |
| <input type="checkbox"/> | <input type="checkbox"/> | SINUS PAIN |
| <input type="checkbox"/> | <input type="checkbox"/> | BLEEDING GUMS |
| <input type="checkbox"/> | <input type="checkbox"/> | HOARSENESS |
| <input type="checkbox"/> | <input type="checkbox"/> | ORAL ULCERS |
| <input type="checkbox"/> | <input type="checkbox"/> | SORE THROAT |
| <input type="checkbox"/> | <input type="checkbox"/> | VOICE CHANGES |