



SOUTH MIAMI HEART SPECIALISTS

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 :

.....



SOUTH MIAMI HEART SPECIALISTS
6200 Sunset Drive, Suite #401
South Miami, Florida 33143

PRIMARY INSURANCE

Name :
Address :
Policy Number :
Group Number :
Effective Date :
Telephone Number :

SECONDARY INSURANCE

Name :
Address :
Policy Number :
Group Number :
Effective Date :
Telephone Number :



SOUTH MIAMI HEART SPECIALISTS
6200 Sunset Drive, Suite #401
South Miami, Florida 33143

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/
Responsible Party

.....
Date



SOUTH MIAMI HEART SPECIALISTS
 6200 Sunset Drive, Suite #401
 South Miami, Florida 33143

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.		Sex		Marital Status		Religion				
Insurance Company		Insurance No.		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 :

FAMILY 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 Heart Attack Nervous breakdown
 Cancer Suicide Stomach ulcers Migraine
 High blood Pressure Asthma Kidney disease Rheumatic heart
 Tuberculosis Hay fever Goiter Insanity
 Diabetes Arthritis Leukemia..... Bleeding tendency
 Arthritis Colitis Congenital heart

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?



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:



SOUTH MIAMI HEART SPECIALISTS
 6200 Sunset Drive, Suite #401
 South Miami, Florida 33143

To be answered by WOMEN only:

- Yes No Are you still having regular monthly menstrual periods? When?
- 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? When?
- 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 stillbirths
- How many premature births
- Date of last menstrual period
- How many miscarriages
- How many cesarean operations
- Any complication of pregnancy

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?



SOUTH MIAMI HEART SPECIALISTS

6200 Sunset Drive, Suite #401

South Miami, Florida 33143

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

- 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?

When or since when?

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 Discharge from penis?
- Yes No Hernia (rupture)?
- Yes No Prostrate trouble?

Describe briefly your present medical symptoms:



SOUTH MIAMI HEART SPECIALISTS
6200 Sunset Drive, Suite #401
South Miami, Florida 33143

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 emergency situation prevented us from obtaining acknowledgment
- Other.....



SOUTH MIAMI HEART SPECIALISTS
6200 Sunset Drive, Suite #401
South Miami, Florida 33143

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.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: 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 Practices. You 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 Consent. We 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 changes. Those 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

Address: 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:**