Omar M Jeroudi, MD PA
17490 Highway 3, Suite A300
Webster, TX 77598
Ph: 281-724-9940 Fax: 832-632-1979

Patient Information

Name_____
First Middle Last

Mailing Address_____
Street City State Zip

Home Phone_____ Cell Phone_____ Work Phone _____

Occupation_____ Employer_____

Date of Birth_____ SSN_____

Gender: ☐M ☐F Race _____ Ethnicity_____ Languages _____

Referring Doctor_____

Preferred Pharmacy_____
Name, Street, Phone

Responsible Party Information (If different than patient)

Guarantor's Full Name_____ Relationship to Patient_____

Mailing Address_____

Home Phone_____ Cell Phone_____ Work Phone _____

Employer_____ Occupation_____

Date of Birth_____ SSN_____

Spouse / Significant Other Information

Spouse's Name _____

Date of Birth_____ SSN_____ Cell Phone _____

Employer_____ Occupation_____ Work Phone_____

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Primary Insurance Information

Name _____

Address _____
Street City State Zip

Phone _____ Policy# _____ Group# _____

Policyholder's Full Name _____ SSN _____

Secondary Insurance Information

Name _____

Address _____
Street City State Zip

Phone _____ Policy# _____ Group# _____

Policyholder's Full Name _____ SSN _____

Emergency Contact Information

Name _____

Address _____
Street City State Zip

Phone _____
Home Cell Other

Relationship to patient _____

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Omar M Jeroudi, MD PA *Notice of Privacy Practices*, which explains how my medical information will be used and disclosed. I understand that this information can and will be used to:

- Conduct and direct my treatment among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations (e.g. quality assessments)

I understand that I may request, in writing, for this practice to restrict how my private information is used or disclosed. I also understand that the practice is not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I am entitled to request and receive a paper copy of the *Notice of Privacy Practices*.

_____
Name of Patient

_____ _____
Signature of Patient or Patient's Parent/Guardian (if applicable) Date

Assignment of Benefits

I hereby assign all medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment directly to Omar M Jeroudi, MD PA for medical services rendered to myself and/or my dependents at this office. I understand that I am responsible for any amount not covered by insurance.

I further authorize Omar M Jeroudi, MD PA to release any information necessary to process the claim and payment of benefits. I authorize the insurance company or health plan administrator to release all pertinent financial information concerning coverage and payments under my policy to Omar M Jeroudi, MD PA.

A photocopy of my signature on this assignment is to be considered as valid as the original.

This assignment will remain in effect until revoked by me in writing.

_____
Patient Name

_____ _____
Patient Signature or Responsible Party Signature Date

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Authorization for Release of Diagnostic Reports and Electronic Information

I authorize Dr. Omar Jeroudi and the staff at Omar M Jeroudi, MD PA to leave diagnostic test results pertaining to my medical care (or if patient is a dependent, for my dependent's medical care) on my answering machine and/or voicemail.

(Please choose one option below and sign next to the option you choose)

_____YES Signature:_____ Date:_____

_____NO Signature:_____ Date:_____

I authorize Dr. Omar Jeroudi and the staff at Omar M Jeroudi, MD PA to provide me appointment reminders, and notification of the availability of diagnostic test results for myself (or if patient is a dependent, for my dependent) within the Omar M Jeroudi, MD PA patient portal.

(Please choose one option below and sign next to the option you choose)

_____YES Email Address: _____

Signature:_____ Date:_____

_____NO Signature:_____ Date:_____

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Financial Policy

Understanding medical care finances can be challenging, especially since an office visit may involve multiple payors. In an effort to provide you with a full understanding of your financial responsibilities as an important aspect of your medical care, we have developed the following policies. Please feel free to ask any questions or discuss any concerns with us.

1. Full payment is due at the time of service.
2. Our office accepts cash, personal checks, and most major credit cards.
3. Our office has made arrangements with many insurance carriers to accept an assignment of benefits. In these instances, we will bill those insurance plans directly. You, however, are still required to pay your co-payment, co-insurance, insurance deductible, and/or fees for services "not covered" by your insurance plan. Payment will be collected at the time of service, or is due upon receipt of a statement from our office.
4. As a courtesy, we may obtain information regarding specific benefits covered and payable under your health insurance plan but it is your responsibility to be aware of the details of your health care coverage, since the benefit information provided to our office by your health insurance company may not be accurate.
5. Patients with an outstanding balance are required to pay their balance before an appointment will be scheduled.
6. There will be a $35.00 charge on returned checks.
7. No show policy – Patients who fail to keep their appointments or cancel less than 24 hours notice more than twice will be dismissed from the practice. If you do not keep an appointment, and you fail to reschedule or cancel at least 24 hours prior to your appointment, you may be subject to a $20.00 cancellation fee. Appointments cancelled within the 24-hour period will be treated as a no show and the no show policy will apply.

_____ _____

Patient Name Date

_____

Patient Signature or Responsible Party Signature

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Acknowledgement of Financial Responsibility

I have read, understand, and agree to the Omar M Jeroudi, MD PA Financial Policy as outlined above. I have requested medical services from Omar M Jeroudi, MD PA on behalf of myself and/or my dependent(s), and understand that by making this request I am financially responsible for any and all charges incurred.

I acknowledge that any benefit information obtained by Omar M Jeroudi, MD PA on my behalf was qualified by the health insurance company with the following statement: 1) This is an estimate of the benefits provided under the insurance contract; 2) Any payment is subject to the coordination of benefits with any other insurance that may cover the services rendered and the coverage being in effect on the date of service; 3) Verification of eligibility or benefits is not a guarantee of coverage or payment and is subject to any policy provisions and exclusions that are in effect at the time services are rendered.

Omar M Jeroudi, MD PA does not accept responsibility for collection of insurance proceeds or for negotiating settlement of disputed claims. If my insurance company does not pay the claim in full, I am responsible for payment of the balance including any finance charges or collection fees that may be included.

_____ _____

Patient Name Name of Responsible Party

(If applicable)

_____

Patient Signature or Responsible Party Signature Date

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General Consent for Evaluation and Treatment

I,_____, have requested to be evaluated and treated by the staff at Omar M Jeroudi, MD PA. I understand that certain office procedures may be appropriate for my medical evaluation and treatment. These procedures may include, but are not limited to, the following:

Exercise (Treadmill) Stress Testing

Pharmacological Stress Testing

Nuclear Myocardial Perfusion Imaging

Positron Emission Tomography

Cardiac Computed Tomography

Holter Monitor

Intravenous line placement

Venous ablation

The general risks of the above stated procedures include: pain, damage to skin or adjacent tissues at the injection or intravenous site, localized swelling, redness, wound, chest pain or discomfort, lightheadedness, dizziness, bradycardia, tachycardia, arrhythmia, myocardial infarction, venous thrombosis and pulmonary embolism, wheezing, nausea, vomiting, radiation exposure, as well as the need for further emergent medical treatment, and potential death in extreme circumstances.

Before any of these procedures are performed (if they are deemed appropriate for your care), the risks and benefits will again be reviewed verbally, and you will be given time to have all of your questions and/or concerns addressed regarding the specific procedure(s).
You may withdraw your consent for any diagnostic or treatment procedure at any time, verbally or in writing.

_____ _____

Patient Name Name of Responsible Party
(If applicable)

_____ _____

Patient Signature or Responsible Party Signature Date

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NEW PATIENT HEALTH HISTORY

In order to treat you safely and effectively, please answer the following questions to the best of your knowledge. If it does not apply to you, then skip the section. This is for our records and will be treated confidentially.

Name:_____Age:_____DOB:_____/_____/_____Ht:_____Wt:_____

What is the reason for your visit (Chief Complaint)?

_____

Do you have any **allergies** to medications? ☐ No ☐ Yes (*Specify medications and reactions*)

_____

Any **allergy** to **iodinated contrast**? ☐ No ☐ Yes Any prior contrast study before? ☐No ☐Yes

Have you had cardiac testing before (Holter, EKG, Stress Test, Echo, Nuclear, CT, MRI)?

☐No ☐Yes: If yes, when and results?_____

Have you ever had **an intolerance to a statin** medication before? ☐ No ☐ Yes

If Yes, what was your reaction? _____

If Yes, indicate which you have taken: ☐ Simvastatin (Zocor) ☐ Atorvastatin (Lipitor)

☐ Pravastatin (Pravachol) ☐ Rosuvastatin (Crestor) ☐ Other_____

Medications – attach a separate sheet if necessary:

Please list ALL medications, non-prescription medications, supplements, herbals, birth-control pills, etc. Please bring your medications with you to your appointment.

Name	Dose/Frequency	Name	Dose/Frequency

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Past Medical History:

Have you ever had a history of:

☐Hypertension/High BP	How many years?_____	Average BP at home?_____
☐High cholesterol	How many years?_____	Latest LDL?_____
☐Heart Stent/Angioplasty (PCI)	When was your last procedure?_____	How many stents/procedures have you had?_____
☐Heart Surgery (Bypass/Valve replacement/Aneurysm/Other)	Type of procedure?_____	When?_____
☐Diabetes Mellitus	How many years?_____	Latest HgbA1c?_____
☐Atrial Fibrillation/Flutter	How many years?_____	On anticoagulation?_____
☐Pacemaker or Defibrillator	When?_____	Any exchanges?_____
☐Ventricular arrhythmia		
☐Peripheral artery/vascular disease	What part of body?_____	Any procedures?_____
☐Venous disease, Pulmonary Embolism	When?_____	On anticoagulaton?_____
☐Bleeding	What type?_____	Outcome?_____
☐Bicuspid Aortic Valve	☐Mitral Regurgitation / Stenosis	☐Aortic Regurgitation / Stenosis
☐Congenital Heart Disease	Explain_____	☐Aneurysm
☐Congestive Heart Failure	Type? Systolic / Diastolic / Unk	

Other past medical history:

☐Sleep apnea	☐Hepatitis	☐Thyroid Disease
☐Cancer	☐HIV	☐Heartburn (GERD)
☐Rheumatologic Illness	☐Arthritis	☐Stroke / TIA
☐Kidney Disease	☐Lung Disease	☐Clotting disorder
☐Dialysis		
☐Other_____	☐Other_____	☐Other_____

Past Surgical History:

_____	_____	_____
_____	_____	_____
_____	_____	_____

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Family History

Do you have a 1st degree blood relative diagnosed with coronary artery disease or stroke before the age of 55 in a male relative or the age of 65 in a female relative? ☐No ☐Yes

If yes, explain_____

Are you adopted? ☐No ☐Yes

Please place a check mark as applicable	Father	Mother	Brother	Sister	Child	Grand-father	Grand-mother	Aunt	Uncle
Diabetes Mellitus									
Peripheral Arterial Disease									
Aortic Aneurysm									
Bicuspid Aortic Valve / Aortic coarctation									
Hypertension									
High Cholesterol									
Coronary Artery Disease									
Kidney Disease									
Clotting / blood disorder									
Lung Disease									

Social History

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

Occupation: _____Education Level: _____

Tobacco Use: ☐Current ☐Prior ☐Never
How many years total of tobacco use?_____ Quit Date (if applicable)_____

Tobacco Method: ☐Cigar ☐Cigarettes _____ Pack/day ☐Smokeless tobacco

Do you drink alcohol? ☐No ☐Yes (How many drinks per week?)_____

Do you exercise? ☐No ☐Yes (How often per week, for how long, and what type?)_____

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Review of Systems

Please let us know within the past 4 weeks if you have felt or experienced any of the following:

Constitutional: ☐Weight gain ☐Weight loss ☐Fatigue ☐Fever ☐Dizziness

Eyes: ☐Change in vision ☐Eye pain ☐Eye redness ☐Dry eyes ☐Itchy eyes

E/N/T: ☐Ear ringing ☐Hoarseness ☐Nose bleeds ☐Post nasal drainage ☐Hay fever ☐Itchy throat ☐Itchy ears ☐Sinus congestion / pressure ☐Ulcers/sores in mouth

Heart: ☐Chest pain ☐Palpitations ☐Leg swelling ☐Fainting ☐Sleeping on >2 pillows

Lungs: ☐Cough ☐Wheezing ☐Shortness of breath ☐Blood tinged sputum

Gastrointestinal: ☐Nausea ☐Vomiting ☐Constipation ☐Diarrhea ☐Black stools ☐Heartburn ☐History of liver disease or abnormal liver tests

Genitourinary: ☐Painful urination ☐Blood in urine ☐Frequent urination ☐Urine incontinence

Skin: ☐Rash ☐Hair loss ☐Itching ☐Problems going out in the sun ☐Hives ☐Nail changes ☐Color changes of hands and feet in cold

Musculoskeletal: ☐Joint pains ☐Joint swelling ☐Joint stiffness ☐Joint redness ☐Muscle aches ☐Back pain

Psych: ☐Anxiety ☐Depression ☐Sleep problems

Neuro: ☐Seizures ☐Vertigo ☐Weakness ☐Numbness ☐Tingling

Endocrine: ☐Feeling too hot ☐Feeling too cold ☐Excessive thirst ☐Enlarging hands or feet

Heme: ☐Easy bruising ☐Abnormal bleeding ☐Abnormal lymph nodes ☐History of transfusion