Jaimela J.Dulaney, M.D., P.A.
2495 Caring Way, Suite C
Port Charlotte, F. 33952
Phone 941-235-9231 fax 941- 235-9236

Dear Madam or Sir,

We are glad you have chosen Dr. Jaimela J. Dulaney and her staff to meet your Cardiology needs. We look forward to working with you. Our goal for you is to remain healthy and live your life to your fullest potential. Our mission statement is ***Comprehensive Cardiac Care with an Emphasis on Caring.***

If you are a "self" referral or were referred by your Primary Care we will need your most recent Cardiac records before your first appointment. That would include any ***heart catheterizations***, / **angioplasty /stents**, or ***by-pass*** reports. If you have had recent echoes, stress tests or blood work we would like those as well. Our goal would be for our staff to review these records before your appointment and make your first visit a productive one for all involved. You will find a ***Medical Records Release Form*** available on the portal. This will help us gather any records you may not have a copy of in your possession.

Please fill out the ***History Form, Privacy Policy, Financial Policy*** and ***Records Release*** in advance and return them to our office as soon as possible.

Thank you again for choosing us for your Cardiac care we look forward to meeting you.

Sincerely,

Jaimela J. Dulaney M.D. and Staff

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Port Charlotte, FL. 33952
(p) 941-235-9231 (f)941-235-9236

CARDIAC MEDICAL HISTORY QUESTIONNAIRE

YOUR PERSONAL INFORMATION:

Today's Date: _____ (mm/dd/yyyy) Date of birth: _____ (mm/dd/yyyy)
Age: ____ Gender : Male ___ Female ___
Weight: _____ (pounds) Height: _____ feet ____ inches

NAME: _____

ADDRESS:
Street _____ Apt # _____
City _____ State _____ Zip code _____

HOME phone number with area code _____

CELL phone number with area code _____

WORK phone number with area code_____

E-MAIL ADDRESS_____

PHYSICIAN INFORMATION: (If known)

Your Primary Care Doctor's:
Name: _____
Address:
Street _____ Suite # _____
City _____ State _____ Zip code _____ Telephone Number (___)_____

Previous Cardiologist
Name: _____
Address:
Street _____ Suite # _____
City _____ State _____ Zip code _____Telephone Number (___)_____

Other Physicians involved in your care_____

Drug:	Dosage	Frequency
Drug:	Dosage	Frequency
Drug:	Dosage	Frequency
Drug:	Dosage	Frequency
Drug:	Dosage	Frequency

RECENT CARDIAC TESTS

Cardiac stress test in past year or scheduled?	○ Yes ○ No	Location	Date
Cardiac catheterization in past year or scheduled?	○ Yes ○ No	Location	Date
Cholesterol test in past year or scheduled?	○ Yes ○ No	Location	Date

PERTINENT SURGICAL PROCEDURES

○ Procedure:	○ Date:
○ Procedure:	○ Date:
○ Procedure:	○ Date:
○ Procedure:	○ Date:
○ Procedure:	○ Date:

CONTRAST CT / BETA BLOCKER CONTRAINDICATIONS

History of allergies ○ NO ○ YES >>>	○ Seasonal/hay fever ○ Xray dye/IV contrast	○ Shellfish ○ Asthma	○ Penicillin ○ Iodine	○ Demerol ○ Sulfa drugs
Please check if you currently have or have had any of the following:				
○ Previous X-ray dye injection	○ Irregular heart rate	○ Heart failure	○ Pacemaker	
○ On chemotherapy	○ Kidney Problems	○ Multiple Myeloma	○ Liver Disease	

Is there any other significant medical or surgical history that you think we should know about?
If so, please describe them in the space below.

_____

_____

_____

_____

_____

_____

_____

If you do not have room for everything, please put the information on a separate sheet

PLEASE Return these forms to our office before your Appointment so we can review them and gather your records.

PLEASE BRING ALL OF YOUR PRESCRIPTION MEDICATIONS TO YOUR OFFICE VISIT.

DO YOU HAVE KNOWN HEART DISEASE ○ **YES or** ○ **NO** ***ONLY CHECK ONE***
Please check all spaces that apply to you

○ High blood pressure	○ Chest pain on exertion	○ Enlarged heart	○ Coronary artery disease
○ Previous heart attack Date:		○ Idiopathic cardiomyopathy	○ Hypertrophic cardiomyopathy
○ Valvular heart disease Date diagnosed:		○ Congestive heart failure	○ Pericarditis
○ Endocarditis	○ Congenital heart disease Type:	○ Previous heart surgery Type:	○ Tachcardia mediated cardiomyopathy

DO YOU HAVE DISEASE IN ARTERIES OTHER THAN THE HEART ○ **YES or** ○ **NO** ***ONLY CHECK ONE***
Please check all spaces that apply to you.

○ Renal insufficiency	○ Peripheral vascular disease	○ Diabetes Year diagnosed	○ On insulin
○ Previous DVT (Leg or arm clots)		○ Other_____	○

RISK FACTOR DETERMINATION (Please check all spaces that apply to you.)

○ Sedentary lifestyle	○ Currently smoking	○ Quit smoking	○ Lifetime non-smoker
○ Regular exerciser How much?	○ Relatives with heart attack ○ Immediate ○ Paternal ○ Maternal	○ Relatives with coronary artery disease ○ Immediate ○ Paternal ○ Maternal	○ High cholesterol Value (if Known)
○ Overweight	○ High stress levels	○ Other_____	

IF FEMALE:

Do you still have periods?	○ Yes ○ No	If no, what age did they stop?
Have your ovaries been removed?	○ Yes ○ No	If yes, at what age?
Are you on hormone replacement?	○ Yes ○ No	Age started_____ Age stopped_____

DO YOU HAVE KNOWN ATRIAL FIBRILLATION (AF) ○ **YES or** ○ **NO** ***ONLY CHECK ONE***
If you answered YES, please check all spaces that apply to you

Type of AF (if known) _____	○ Intermittent	○ Continuous	○ Duration (if known)
Aware when you are in AF ○ Yes ○ No	Previous cardioversion? ○ Yes ○ No	Previous EP study? ○ Yes ○ No	Previous cardiac ablation? ○ Yes ○ No
Previous echocardiogram? ○ Yes ○ No	Pacemaker? ○ Yes ○ No	Type, brand and model (if known)	

MEDICATIONS:

Are you on cholesterol or lipid lowering medication?	○ Yes ○ No	How long?_____
Are you on high blood pressure medication?	○ Yes ○ No	How long?_____
Are you on daily aspirin?	○ Yes ○ No	How long?_____

PERTINENT MEDICATION LIST

Patient Questionnaire

OFFICE FINANCIAL POLICY ~ Dr Jaimela J. Dulaney

PATIENT NAME _____ DATE: _____

BASIC POLICY: Payment for service is due in full at time of service.

FOR PATIENTS WITH INSURANCE: As a convenience, we will bill your primary and secondary insurance carriers. Copayments and deductibles are due at the time of service. No deductibles or copayments will be written off unless financial hardship is proven. If an insurance carrier has not paid within 60 days of billing, payment is due in full from you, the patient.

MEDICARE PATIENTS: We will bill Medicare and your secondary insurance carrier for you. All copayments or deductibles are due and payable at the time service is provided. No deductibles or copayments will be written off unless financial hardship is prove.

MEDICARE PATIENTS / SIGNATURE ON FILE: I request payment of authorized Medicare benefits be made on my behalf to DR. DULANEY for any services provided to me by the listed provider. I authorize Dr. Dulaney to release to The Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim.

In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services.

SIGNATURE: _____ DATE: _____

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurances, please read and sign below.

I hereby assign all major medical benefits to which I am entitled, either by private insurance or any other health plans, to DR DULANEY. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the release of all information necessary to secure the claim payment.

SIGNATURE: _____ DATE: _____

FEE FOR NO-SHOW: We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances. In this event, we ask that you call our office and cancel your appointment 24 hours before the scheduled visit. This courtesy allows the office staff to schedule another patient who is also in need of medical care. There will be a $25 fee for all "no-show" appointments.

I have read, understood, and agreed to the above financial policy for payment of professional fees.

The patient is ultimately responsible for all professional fees.

SIGNATURE: _____ DATE: _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that apply):

___ HOME TELEPHONE

___O.K to leave message with detailed information

___Leave message with call-back number only

___WRITTEN COMMUNICATION

___O.K to mail to my home address

___O.K to mail to my work/office address

___O.K to fax to this number

___WORK TELEPHONE

___O.K to leave message with detailed information

___Leave message with call-back number only

___OTHER: Please provide below, anyone we are able to share information with.

CONTACT NAME: PHONE NUMBER:

_____

_____

_____

_____

_____

Patient signature_____ Date_____

Printed name _____ Date of Birth_____

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Medical Records Release

NAME:_____

SSN:_____

DOB:_____

I authorize Dr. Dulaney to: ( ) Obtain records from ( ) Send records to

NAME OF HOSPITAL/DOCTOR:_____

_____

CITY **STATE** **ZIP CODE**

_____

PHONE NUMBER **FAX NUMBER**

( ) Continued Medical Care **( ) New Patient**

RECORDS NEEDED:_____

_____

I understand that my records may contain information about alcohol and/or drug treatment, mental health or psychiatric treatment, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need as indicated above. I also understand that this consent will expire six (6) months after the date below, or when the information requested with this consent has been received/released. A photocopy of this release shall have the same effect as the original.

Name_____ Date_____