Rachel Eidelman, M.D. ,F.A.C.C.
Bethesda Heart Hospital
Director, Center For Women's Heart Care

Patient Contact Information

Patient

Name: _____

Permanent Address: _____

City, State, Zip Code: _____

Social Security Number: ____ - ____ - ____ *Date of Birth*: ___ /___ / ____

Home Phone: ( ) _____ *Cell Phone:* ( ) _____

Work phone: ( ) _____ *E-mail*: _____

*Preferred Contact: Phone*_____ *or Email*_____

*Race:*_____ *Ethnicity:*_____

Religion: _____

Primary Language Spoken: _____ *Secondary Language*: _____

Marital Status: *Circle one* Single Married Divorced Widowed

Significant Others Name: _____

Do you have a Living Will? *Circle one*: Yes No (If not, we encourage you to do so)

Do you have a DNR form? *Circle one*: Yes No

Person authorized to make medical decisions on your behalf including, but not limited to, life prolonging procedures in the event you are medically incapable. (Power of Attorney)

Name:_____

Address:_____

Phone #:_____

Primary Care Physician

Name: _____ Telephone: ( ) _____

Address: _____

_____ Fax: ( ) _____

Emergency

In case of Emergency, Please Contact: _____

Telephone: ( ) _____ Cell: ( ) _____

Relationship: _____

Pharmacy Name: _____ Pharmacy Number: _____

Pharmacy Address: _____

How did you hear about us: _____

APPOINTMENT CANCELLATION/ NO SHOW POLICY

Our practice is committed to providing quality health care to our patients. We work diligently to maintain our high level of personalized service and make every effort to accommodate our patients needs for office visits in a timely manner

We understand that emergencies arise as they do for us, however when a patient cancels an appointment without adequate notice or fails to keep an appointment without any notice, we can not use the time to serve the needs of other patients. We respectfully request your understanding to our policy as stated below.

Failure to give 24 hour notice of cancellation or no showing to an appointment will result in a $25 charge. Insurance companies do not cover this fee. It will be billed to your account. You will receive a call the day before to remind you of your appointment.

Please use: 561-244-7720 for your calls. This is the only telephone line that is answered 24 hours a day.

Thank you for your consideration and understanding of our policy.

I have read the cancellation/ no show policy:

_____ _____

Patient Signature Date

BETHESDA HEALTH

CONSENT RECORD

1. FINANCIAL AGREEMENT-I hereby guarantee payment of all charges incurred for services render by Bethesda Health Physician Group by authorized treating physician(s). Further, I guarantee payment of all attorney fees, court costs and collection charges incurred in the event collection action is initiated by Bethesda Health Physician Group.
2. MEDICARE/MEDICAID ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATIN AND PAYMENT REQUEST. I assign benefits and request that payment be made directly to Bethesda Health Physician Group. I understand that I am responsible for any deductibles and co-payments applicable.
3. USES AND DISCLOSURES OF HEALTH INFORMATION – I understand that Bethesda Health Physician Group will use and disclose my personal health information to provide treatment and process claims. This includes release of information to insurance carriers, 3rd party payers or their agents, with any right to privacy waived including any treatment for mental illness, alcohol abuse, drug abuse or HIV as may be necessary. Further, my information and medical records may be disclosed to members of the hospital's medical staff involved in my subsequent care and treatment. For details of uses and disclosures, refer to Notice of Privacy Practices.
4. CONSENT FOR GENERAL MEDICAL TREATMENT – I hereby authorize Bethesda Health Physician Group in charge of my care to administer any treatment, receive results of tests and services rendered, to administer medications deemed necessary or advisable in my diagnosis and treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments of examinations at Bethesda Health Physician Group.
5. PRIVACY PRACTICES – I have been made aware of Bethesda's Privacy practices as described in the Notice of Privacy Practices.
6. I authorized the release of any medical information necessary to process my claims. I assign benefits and request payment be made to Bethesda Health Physician Group. I permit a copy of these authorizations to be used in place of the original. I accept responsibility for all charges incurred and I am responsible for payment. Where applicable, regulations pertaining to Medicare assignment and HMO assignment of benefits apply.

I understand that this consent is subject to revocation at any time to the extent that action has been taken in reliance thereon. I certify that I have read the foregoing, received a copy thereof, and I am the patient, the patient's legal representative or dully authorized by the patient as the patient's general agent to execute the above and accept its terms. I also fully understand the consent contained in this record and voluntarily execute it.

Patient Signature: _____ Date: _____
If other than patient, state relationship

Witness Signature: _____

PATIENT CONTACT

Contact Information*
The following people, other than duly designated guardian or conservator, are authorized to discuss my medical condition or billing information:

1._____
Name Relationship Phone Number

2._____
Name Relationship Phone Number

Print Name: _____ Date: _____

Signature: _____ Phone number: _____

***Please Note:** This contact information will remain in effect unless change is received from you in writing.

10301 Hagen Ranch Road, Suite B5, Boynton Beach, FL 33437 • Phone: 561-244-7720, Fax: 561-244-7724

BETHESDA HEALTH

Rachel Eidelman, M.D.
Phone: 561-244-7720
Fax: 561-244-7724

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
I hereby authorize that my Medical Records be released from

Physician Name/Clinic: _____

Address: _____

I hereby authorize that my Medical Records be released to Fax: 561-244-7724

Physician Name/Clinic: Bethesda Health Physician Group/ Dr. Rachel Eidelman

Address: 10301 Hagen Ranch Road, B5, Boynton Beach, FL 33437

Information Requested

- O For dates of service: From: _____ Through: _____
- O Physician notes
- O Lab results
- O X-ray reports
- O Complete record
- O Other: _____

Purpose for Use of Disclosure of Protected Health Information

- O Permanent Transfer
- O Referral
- O Other: _____

Note: fee may be assessed for records requested for personal use

Patient Information

Printed Name: _____ Date of Birth: _____ SSN #: _____

SENSITIVE INFORMATION: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
REDISCLOSURE: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.
RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time; I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.
ORTHER RIGHTS: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed.
EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: *(If I do not specify an expiration date, event, or condition, this authorization will expire in twelve (12) months.)*

Signature of Patient or legal representative: _____

If signed by legal representative, relationship to patient: _____ Date: _____

PATIENT NAME: _____

DATE: _____

Have you had any recent: *Recientemente, ha tenido*:

Weight gain *aumento de peso*	☐ YES	☐ NO
Fatigue *fatiga*	☐ YES	☐ NO
Night sweats *sudores nocturnos*	☐ YES	☐ NO
Fevers *fiebre*	☐ YES	☐ NO
Chills *Escalofríos*	☐ YES	☐ NO
Weakness *Debilidad*	☐ YES	☐ NO
Seizures *Convulsiones*	☐ YES	☐ NO
Numbness *Entumecimiento*	☐ YES	☐ NO
Trouble walking *Dificultad para caminar*	☐ YES	☐ NO
Falls *Caídas*	☐ YES	☐ NO
Passing-out *Desmayos*	☐ YES	☐ NO
Shortness of breath *Falta de aliento*	☐ YES	☐ NO
Wheezing *Dificultad al respirar*	☐ YES	☐ NO
Cough *Tos*	☐ YES	☐ NO
Coughing up blood *Tos con sangre*	☐ YES	☐ NO
Abdominal pain *Dolor abdominal*	☐ YES	☐ NO
Heartburn *Acidez*	☐ YES	☐ NO
Vomiting *Vómito*	☐ YES	☐ NO
Diarrhea *Diarrea*	☐ YES	☐ NO
Constipation *Estreñimiento*	☐ YES	☐ NO
Change in stool *Cambio en las heces*	☐ YES	☐ NO
Change in bowel frequency *Cambio en la frecuencia de deposiciones*	☐ YES	☐ NO
Painful urination *Dolor al orinar*	☐ YES	☐ NO
Incontinence *Incontenencia*	☐ YES	☐ NO
Blood in urine *Sangre en la orina*	☐ YES	☐ NO
Excessive thirst *Sed excesiva*	☐ YES	☐ NO
Excessive hunger *Hambre excesiva*	☐ YES	☐ NO
Heat or cold intolerance *Intolerancia al Calor o frío*	☐ YES	☐ NO
Mood changes *Cambios de humor*	☐ YES	☐ NO
Depression *Depresión*	☐ YES	☐ NO
Hair loss *Pérdida de cabello*	☐ YES	☐ NO
Skin changes *Cambios en la piel*	☐ YES	☐ NO
Headaches	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO
Pregnancies	☐ YES	☐ NO
If so, diabetes with pregnancy?	☐ YES	☐ NO
High blood pressure with pregnancy?	☐ YES	☐ NO
Any other problems associated with pregnancy?	☐ YES	☐ NO

How many days per week do you exercise? ☐3 ☐5 ☐7
¿Cuántos días a la semana hace usted ejercicio?

How many minutes do you exercise each time? ☐30 ☐45 ☐60
¿Por cuántos minutos hace ejercicio cada vez?

What kind of exercise do you do? _____
¿Qué tipo de ejercicio hace?