CARDIAC ARRHYTHMIA CENTER
OF THE PALM BEACHES
SIMIE B. PLATT, MD

1002 S. Old Dixie Highway
Suite 304 Jupiter, FL 33458
561-630-8570 561-630-8572
www.CACpalmbeach.com

NEW PATIENT INFORMATION SHEET

Name____ Language ________________________

Local Address ____

City____________________________ State_______________________ Zip___________________

Phone # _______________________ Cell #______________________ Email___________________

Race ___________________ Ethnicity_________________ Nationality______________________

Pharmacy____ **Phone #** ________________________

Date of Birth ____________________________

** We request the name of one person allowed to act on your behalf in the event we need to make a change in your medication, discuss any test results, or reschedule an appointment in your absence.**

Contact _________________________________ Phone #___________________________________

Relationship _____________________________ Cell #____________________________________

Medical Insurance ___________________________ 2nd Insurance_____________________________

Referring M.D. ______________________________ Phone #__________________________________

Primary M.D. _______________________________ Phone #__________________________________

Assignment Release: I hereby authorize the above named carriers, authorized agents, and clients thereof, to release any pertinent information required for settlement of services provided by Simie B. Platt M.D. with payment going directly to same. I further acknowledge and accept financial responsibility for any services, deductibles, co-pays, and other miscellaneous fees not covered by my insurance company.

Acknowledge of Privacy Act Information: I have reviewed my copy of the Notice of Privacy Practices provided by Simie B. Platt M.D., and I do understand my rights.

Consent to Treatment: I agree for a health professional to provide care.

Signature: ____ Date:__________________________

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Do you have a history of?

High Blood Pressure ____________ Thyroid ____________

Diabetes ____________ Stroke ____________

High Cholesterol ____________ Syncope ____________

Prostate Enlargement ____________ Asthma ____________

COVID +_____ Vaccine_____ Dates:____________ Other ____________

Bypass surgery ____________ Cholecystectomy ____________

Heart valve surgery ____________ Hysterectomy ____________

Pacemaker ____________ Hernia repair ____________

Defibrillator ____________ Tonsillectomy ____________

Angioplasty/stents ____________ Mastectomy ____________

Ablation ____________ Other____________

Social History- Check the appropriate spaces and fill in the accurate amounts of standard portions

Employed ________ Retired________ Occupation ____________

Single ________ Divorced ________ Married ________ Widowed________

Children ________ Ages ________ Religious Affiliation____________

Mental Activity: (Reading, Paying bills, Discussions, Work)__ Light __ Moderate__ Heavy
Physical activity:__ Light __ Moderate__Heavy Hours per day:______
Alcohol:___never, Beer(s)_____per week, Liquor_____ per week, Wine____ per week How many years? ______
Smoking:___never,___current,___ previous,___discontinued, Quantity:________How many years?______
Nutritional Information: ___ Low sodium,___Diabetic Diet,___Low fat diet,___Vegetarian/vegan,___ Low cholesterol,___Other
Miscellaneous drugs:___ Antacids,___ Diet pills,___ Laxatives,___Nutrasweet,___Decongestants, ___OTC histamines,___Other

Are you allergic to Iodine Contrast?____________

Do you have any objection to receiving blood transfusion or blood products? ____________

Family History (check all that apply)

Parents: Mother: Age:________ Died:________ Father: Age:________ Died:________
Do your immediate family members have a history of? Heart Attack ______ Bypass Surgery or Angioplasty______
Sudden death______ Atrial Fibrillation______ High blood pressure______Diabetes______Congestive Heart failure______
Cancer (type)____________

Reviewed by:________

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Review of symptoms—Circle only the ones you NOW have or have had recently

Allergies: ______________________________ None

General: Weakness___ Fatigue___ Fever___ Chills___ Night sweats___ Fainting___ None

Skin: Color changes in moles___ Size changes in moles___ Red dots/Spots___ None

Head: Headaches___ Head injuries___ None

Eyes: Transient loss of vision___ Glaucoma ___ None

Ears: Recent loss of hearing ___ Dizziness___ Loss of balance ___ None

Nose: Nasal Discharge___ Post nasal drip___ None

Mouth: Dental Problems___ Oral sores___ None

Throat: Difficulty swallowing___ Hoarseness present for more than 2 weeks___ None

Neck: Neck enlargement___ Neck lumps___ Neck masses___ None

Lungs: Cough ___Phlegm ___ Coughing blood___ Shortness of breath___ Wheezing___ Pain in lungs___ None

Blood: Anemia___ Easy bruising___ Prolonged bleeding___ Swollen/painful nodes___ None

Gastrointestinal: Change in bowel habits___ Irregular bowels___ Abdominal pain___ Nausea___ Vomiting___ Bloating___ Belching___ Heartburn___ Indigestion___ Constipation___ Diarrhea___ Gas___ Hemorrhoids___ Hernias ___ Poor appetite___ Food Intolerance___ Bloody/Black tar-y stools___ Rectal bleeding___ None

Gynecological: Post menopausal bleeding___ Hot flashes___ Mood swings___ Night sweats___ None

Musculoskeletal: Muscular pain___ Muscle weakness___ Joint stiffness/pain___ Joint swelling___ Joint deformities___ Curvature of spine___ None

Neurological: Seizures___ Vertigo___ Hand trembling___ Loss of sensation___ Uncoordinated___ Transient paralysis of upper or lower extremities___ Slurred speech___ Tingling/burning/numbness___ Loss of memory___ Disorientation___ Gait shuffling___ None

Psychiatric: Insomnia___ Irritability___ Anxious/stressed___ Panic attacks___ None

Reviewed by:_____

HIPAA Notice of Privacy Practices

Simie B. Platt, M.D.

1002 South Old Dixie Hwy. Suite 105. Jupiter, FL. 33458 – (561-630-8570)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as Required By Law, Public Health issues as required by law, Communicable Disease: Health Oversight. Abuse or Neglect. Food or Drug Administration requirements. Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation. Research: Criminal Activity: Military Activity and National Security. Workers Compensation: Inmates: Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclose indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records, psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Huan Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice to our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Furthermore in order to protect your health information please do not disclose any Protected Health Information when leaving voice messages for the office staff and or doctor.

Signature below is only acknowledgment that you have reviewed the Notice of our Privacy Practices. A separate brochure outlining these rights is available to you, upon your request to the Office Manager.

Print name____________________________ Signature ______________________________ Date______________________

Simie B. Platt, M.D., F.A.C.C.

DOS: ___ / ___ / ___
Patients Name: ____________
DOB: ___ / ___ / ___
REFERRING: ____________
PCP: ____________

DO YOU HAVE A HISTORY OF?

High blood pressure ____________
Diabetes ____________
High Cholesterol ____________
Prostate enlargement ____________
Other ____________

Thyroid ____________
Stroke/TIA ____________
Syncope ____________
Asthma ____________
REVIEWED BY: _____

Bypass surgery ____________
Heart valve surgery ____________
Pacemaker ____________
Defibrillator ____________
Angioplasty/stents ____________
Other ____________

Cholecystectomy ____________
Hysterectomy ____________
Hernia Repair ____________
Tonsillectomy ____________
Mastectomy ____________
REVIEWED BY: _____

SOCIAL HISTORY – Check the appropriate boxes and fill in the accurate amounts of standard portions.

Employed _______ Retired ______ Occupation ____________
Single _______ Divorced ______ Married _______ Widowed _______
Number of Children _____ Ages: ________ Religious affiliation: ____________

Mental Activity: (Reading / Paying Bills / Political Discussion Group / Work) _ Light _ Moderate _ Heavy Physical Activity: (Exercise / Sports / Gardening, etc.) _ Light _ Moderate _ Heavy Hours Per Day: ____________
Alcohol: _ Never _ Beer(s) ____ Per Week _ Liquor ____ Per Week _ Wine ____ Per Week How Many Years? _
Smoking: _ Never _ Current _ Previous _ Discontinued Quantity: _________ How Many Years?: _______
Nutritional Information: _ Low Sodium _ Diabetic Diet _ Low Fat Diet _ Vegetarian Diet _ Low Cholesterol _ Other
Miscellaneous Drugs: _ Antacids _ Diet Pills _ Laxatives _ NutraSweet _ Decongestants _ OTC histamines _
Other ____________

Are you allergic to iodine contrast? __________

Do you have any objection to receiving blood transfusion or blood products? ________

REVIEWED BY: _____

Family History (Check all that apply):

Parents: Mother: age: ___________ Died at: ____________
Father: age: ___________ Died at: ____________
Do your immediate family members have a history of?
Heart Attack _________ Bypass Surgery or Angioplasty ____________
Sudden Death _________ Arial fibrillation ___________ High Blood Pressure
Diabetes _________ Congestive Heart Failure ___________ Cancer (type):___________

REVIEWED BY: _____

Simie B. Platt, M.D., F.A.C.C.

DOS: ___ / ___ / ___
Patients Name: ____________
DOB: ___ / ___ / ___
REFERRING: ____________
PCP: ____________

REVIEW OF SYMPTOMS – Circle only the ones you NOW have or have had recently
Allergies: NONE ___

General: Weaknesses_ Fatigue _ Fever _ Chills _ Night Sweats _ Fainting _ NONE ___

Skin: _ Color changes in moles _ Size changes in moles _ Red Dots/Spots _ NONE ___

Head: _ Headaches _ Head injuries _ NONE ___

Eyes: _ Transient loss of vision _ Glaucoma _ NONE ___

Ears: _ Recent loss of hearing _ Dizziness _ Loss of balance _ NONE ___

Nose: _ Nasal discharge _ Post nasal drip _ NONE ___

Mouth: _ Dental problems _ Oral sores _ NONE ___

Throat: _ Difficulty swallowing _ Hoarseness, present for more than two weeks _ NONE ___

Neck: _ Neck enlargement _ Neck lumps _ Neck masses _ NONE ___

Lungs: _ Cough _ Phlegm _ Coughing blood _ Shortness of breath _ Wheezing _ Pain in lungs _ NONE ___

Blood: _ Anemia _ Easy bruising _ Prolonged bleeding _ Swollen nodes _ Painful nodes _ NONE ___

Gastrointestinal: _ Change in bowel habits _ Abdominal pain _ Nausea _ Vomiting _
Abdominal bloating _ Belching _ Heartburn_ Indigestion _ Irregular bowels _ Constipation _
Diarrhea _ Gas _ Hemorrhoids _ Hernias _ Poor appetite _ Food intolerance_ Bloody stools _
Black tarry stools __ Rectal bleeding NONE ___

Genitourinary: _ Urinary frequency _ Frequent urination _ Urinary stones _ Urinary burning _
Bloody urine _ Urethral discharge_ Urination at night _ NONE ___

Gynecological: _ Post-menopausal bleeding _ Hot flashes _ Mood swings _ Night sweats _ NONE ___

Musculoskeletal: _ Muscular pain _ Muscle weakness _ Joint stiffness _ Joint pain _
Joint swelling _ Joint deformities Curvature of spine _ NONE ___

Neurological: _ Seizures _ Vertigo _ Hand trembling _ Loss of sensation _ Incoordination _
Transient paralysis of upper or lower extremities _ Slurred speech _
Tingling / burning / numbness _ Loss of memory _ Disorientation _ Gait shuffling _ NONE___

Psychiatric: _ Insomnia _ Irritability _ Anxiousness/ stress _ Panic attacks NONE___

REVIEWED BY: ____

Simie B. Platt, M.D., F.A.C.C.

DOS: ___ / ___ / ___
Patients Name: ____________
DOB: ___ / ___ / ____
REFERRING: ______________
PCP: __________________

CHIEF COMPLAINT & PRESENT ILLNESS: **DO NOT COMPLETE**

ARRHYTHMIA MONITOR: ______________________________

EST: ______________________________

ECHO: ______________________________

CATH: ______________________________

Physical Exam: __________ BP = __________ HR = __________ R = __________

SKIN: WNL - warm, dry, no lesions or rashes abnormal ____________
EYES: WNL - anicteric, non-injected, conj pink abnormal ____________
MOUTH: WNL - oral mucosa abnormal ____________
LUNGS: WNL - lungs clear bilaterally abnormal ____________
NECK: WNL - supple, trach midline, no JVD or bruits, carotid upstrokes normal abnormal
CV: WNL - regular irregular
ABD: WNL – soft, non tender
EXT: WNL – no edema Pulses
NEURO: WNL – grossly intact

Assessment and Plan:

- The risks, alternatives and benefits were discussed with the patient. ______

____
MD Signature

MEDICATIONS SUMMARY

PATIENT NAME: **DOB:**

ALLERGIES

	DATE								
Medications									