



**ADVANCED**  
**HEART & VASCULAR**  
**INSTITUTE**

**Eli S. Levine, MD**  
**New Patient Intake Form**

Today's Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Patient Name and date of birth:

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First	Last	Date of Birth
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SSN: \_\_\_\_\_

Gender (circle one): Male      Female

Home address: \_\_\_\_\_

Email address: \_\_\_\_\_

Phone: \_\_\_\_\_ (circle one) Home    Cell    Work

Secondary phone: \_\_\_\_\_ (circle one) Home    Cell    Work

Emergency contact name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Emergency contact phone number: \_\_\_\_\_

**What is your ethnicity?**

Hispanic or Latino

Non-Hispanic or Latino

Decline

**What is your race?**

American Indian/Alaska native

Asian

African American/Black

Nat. Hawaiian/Pacific Islander

Caucasian/White

Other Race

Decline

Who is your primary care physician \_\_\_\_\_

Primary care phone number \_\_\_\_\_





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**Personal Medical History**

- High blood pressure             yes     no
- CHF                                     yes     no
- stroke/TIA                         yes     no
- Diabetes                             yes     no
- Bleeding disorder                 yes     no
- Coronary artery disease         yes     no
- PAD/PVD                           yes     no
- Asthma/COPD                     yes     no
- Liver disease                       yes     no
- HIV/AIDS/Hep C                 yes     no
- Kidney disease                     yes     no
- High cholesterol                  yes     no
- Cancer                               yes     no
- Significant weight loss/gain     yes     no

**FAMILY** history of cardiovascular/Heart disease (such as heart attack, stroke, stents, heart surgery, sudden death, congestive heart failure, etc)?

Yes \_\_\_\_\_                      No \_\_\_\_\_

If yes, provide details:

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**Acknowledgement of Receipt of Notice Of Privacy Practices**

**\*\*you may refuse to sign this acknowledgement\*\***

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 acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other

**Medical Record Release**

I, \_\_\_\_\_ request all medical records including but not limited to: EKG's, echocardiograms, stress tests (stress echo or nuclear stress tests), non-invasive and/or invasive vascular imaging results/findings, cardiac cath & interventional cardiology procedure reports, pacemaker/ICD information, h&p, blood results, x-rays, and any other information that pertains to my health be sent to:

**Eli S. Levine, M.D., P.A.**

**951 NW 13<sup>th</sup> Street**

**Suite 4B**

**Phone: 561-235-5621**

**Fax: 561-235-5495**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



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**Eli S. Levine, M.D., P.A.**

**Consent for Use and Disclosure  
Of Health Information**

**Section A: Patient Providing Consent**

Name/SSN : \_\_\_\_\_

Address/Phone: \_\_\_\_\_

**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 and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice, which will contain the changes.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

**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 our office. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and we may decline to treat you or to continue treating you if you revoke this Consent.

I authorize my medical information to be shared with the following individual(s):

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_

I, \_\_\_\_\_, have had full opportunity to read and consider 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 health care operations.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_