William M. Hudson, M.D.,F.A.C.C.

Patient Authorization

I, ____ , authorize the use and/or disclosure of my health information as set forth below:
(print name)

The following health information may by used and/or disclosed pursuant to this authorization: *All of my health information* ____ **yes**

____**no** , please specify:____

I authorize The office of William M. Hudson , M.D. , F.A.C.C to make the requested use or disclosure of my health information:

I authorize the following person(s) or class of person(s) to receive my health information: ***fill in any that apply***

Spouse ____
Print name

Emergency Contact ____
Print Name

Family members:

____ Phone#______________________________ ______________________
Print Full name relationship to you

____ Phone#______________________________ ______________________
Print Full name relationship to you

Caretakers: ____ Phone#___________________________
Print Full name

Other: ____ Phone#______________________________ ______________________
Print Full name relationship to you

- **This authorization expires 10 years from the date signed below unless otherwise specified here: ______________________**
- I understand that I have the right to revoke this authorization at any time, except to the extent that the person(s) (or class of person(s)) to whom I have authorized such use and/or disclosure have acted in reliance upon this authorization. In order to revoke this authorization, I must provide William M. Hudson, M. D., F.A.C.C., in writing specifically revoking this authorization.
- I understand that my health information may no longer be protected by the federal privacy protection regulations, 45 C.F.R. parts 160 and 164, if my health information is used or disclosed pursuant to this authorization.

____ ______________________
Signature of individual or personal representative Date

____ ______________________
Name of individual or personal representative If applicable, relationship to individual

Name: ______________________________ Date:__________
(last) (first) (MI)

Sex: M F Date of Birth:__________ Social Security #:__________

Address:__________ ______ __________
(street) (APT #) (city) (state) (zip)

Home Phone: (____)__________ Work Phone: (____) __________

**Optional* Cell Phone: (____)__________

Marital Status: __________ Spouse's Name: __________
(last) (first) (MI)

Employment status: ____ full-time ____ part-time____ retired ____ disabled ____ student

Employer: __________Job title:__________

Emergency Contact: (*outside of your household*): Name: __________

Phone: (____) __________ relationship to you:__________

Primary Insurance: __________ Date effective:__________
Policy or ID # __________ Group__________
Name as it appears on Card: __________

Is the above insurance policy through another family member other than you, the patient?

____No ____ Yes, *if yes please fill out area below:*

Name of Policyholder:__________relationship to you:__________
DOB:__________ Policyholder's SS #__________

Secondary Insurance: __________ Date effective:__________
Policy or ID # __________ Group__________
Name as it appears on Card: __________

Is the above insurance policy through another family member other than you, the patient?

____No ____ Yes, *if yes please fill out area below:*

Name of Policyholder:__________relationship to you:__________
DOB:__________ Policyholder's SS #__________

Who referred you to our office?__________

Who is your primary care/family doctor: __________ City:__________

Statement of Medical Insurance Coverage and Financial Policy

(please read carefully and sign below)

1. I understand that I am responsible for verifying my insurance coverage and benefits for all services rendered by William M. Hudson, M. D.,

2. I understand that I will be financially responsible for those charges not covered by my insurance carrier.

3. I understand that if I do not have insurance benefits that I am responsible for payment of any charges incurred.

4. I understand that I am responsible for any co-payments at the time services are rendered.

5. I understand that I am responsible for verifying any pre-certification and referral requirements for services rendered by William M. Hudson, M.D.,

6. I hereby authorize my insurance carrier to pay directly to William M. Hudson, M.D., for surgical and/or medical services rendered.

I have read items 1 through 6 above and agree to the policy.

_______________________________________ ____________________

Signature of Patient or Guardian Date

Name:__________________________ Age:__________ Race:______________

Describe your symptoms / reason for your visit: ______________________________

List any allergies (to medications, food):______________________________

Are you allergic to contrast dye, Iodine or Iodine-containing foods such as shrimp?:__________

Please list **ALL** current medications and dosages (include over the counter and herbal medications)__________

____

____

HAVE YOU EXPEREINCED ANY OF THE FOLLOWING SYMPTOMS? *(CHECK ALL THAT APPLY)*

____ Chest pain
____ Shortness of breath when laying down
____ I am dizzy sometimes
____ Legs swelling
____ Leg aches with activity
____ Shortness of breath
____ Increased fatigue from daily activities
____ I have "palpitations" or "irregular heart beats"
____ Faintness or "passing out"
____ heartburn

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS: *(CIRCLE ALL THAT APPLY)*

High blood pressure
High cholesterol
Heart attack
Heart murmur or valve problems
Congestive heart failure
Irregular heart beat
Diabetes
Blockages of neck arteries
Stroke or TIA
Chronic bronchitis or emphysema ("COPD")
Asthma
Aneurysms of blood vessels
Liver Disease
Hepatitis
Seizures
Kidney disease
Stomach ulcers
Blood clots
Bleeding problems
Anemia
Arthritis

List any other medical conditions not listed above: ______________________________

____

PLEASE CHECK AND PROVIDE DETAILS IF YOU HAVE HAD ANY OF THE FOLLOWING:

____Heart Bypass Surgery : ______________________________
date facility name and location Surgeon

____ Heart valve surgery :______________________________
date facility name and location Doctor

____Pacemaker : ______________________________
date facility name and location Doctor

Heart angioplasty / stents: ______________________________
date facility name and location Doctor

List all other past surgeries / procedures: (include dates):______________________________

____

____

Do you smoke? _____ never did _______ used to: quit date: __________ _______yes how much? __________

Do you consume alcohol? __________ if yes, how much per week?__________________

Do you use/ have you used recreational drugs?_________Describe__________________

Does heart disease run in your family? *(please describe)*:______________________________

____