

Today’s Date: / / Patient Name and date of birth:

**Eli S. Levine, MD**

**New Patient Intake Form**

First Last Date of Birth

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? What is your race?**

Hispanic or Latino American Indian/Alaska native   
Non-Hispanic or Latino Asian

Decline African American/Black

Nat. Hawaiian/Pacific Islander   
Caucasian/White

Other Race

Decline

Who is your primary care physician

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



What is the name and location of your preferred pharmacy?

Pharmacy phone number:

ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications are you currently taking?   
(**Include name, dose, and frequency**)

\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

Smoking status (circle one)   
Never smoker

Former smoker

Light tobacco smoker   
Current some day smoker Current every day smoker Heavy tobacco smoker

Do you drink alcohol? (circle one) yes no

If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_



**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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**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,   
pacer/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 13th Street**

**Suite 4B**

**Phone: 561-235-5621**   
**Fax: 561-235-5495**

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

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

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



**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   
contracting 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** \_\_\_\_ / \_\_\_\_/ \_\_\_\_