Heart & Vascular Center
of
Watauga Medical Center

located inside Watauga Medical Center
336 Deerfield Road | Boone, NC 28607
(828) 264-9664 | fax: (828) 264-8144
apprhs.org/heart

This new patient information packet includes directions to our office and contact information for your records. Our Billing & Insurance Information, Notice of Privacy Practices and Patient Bill of Rights & Responsibilities are available at the front desk or online at apprhs.org.

Enclosed is paperwork that you will need for your upcoming appointment. Please complete the paperwork and bring it with you at your appointment time. If you have a primary care provider that has your medical records, please call them and request that your records be sent to our office so that we can better serve you. We look forward to seeing you at your appointment. If you are unable to keep your appointment, please notify us at least 24 hours in advance by calling (828) 264-9664.

Our office is available to you by phone from 8:00 a.m. - 5:00 p.m. Monday - Friday. If you have any questions, please call our office manager at (828) 264-9664. If you need to speak with a physician after hours, please call (828) 262-4100 to reach the physician on call or dial 911 if you are having a medical emergency.

For your first appointment at the Heart & Vascular Center, please arrive 30 minutes early to complete your registration and bring the following:

- ☐ Insurance Card
- ☐ Pharmacy Information
- ☐ Medical Records
- ☐ Payment
- ☐ Current Medications/Prescription Bottles
- ☐ Questions for doctor
- ☐ Completed forms
- ☐ Photo ID

____
has an appointment with

____

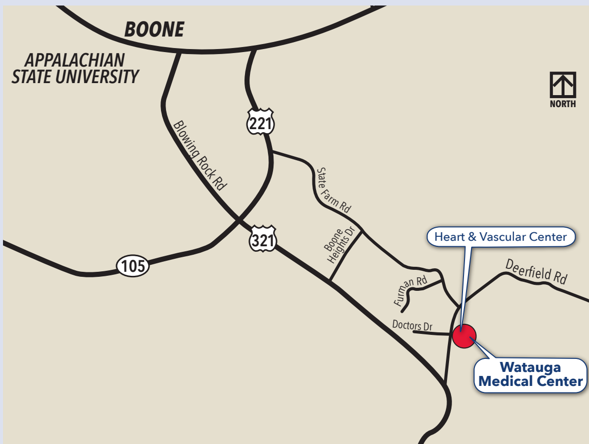
☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri.

_______________________date ____________a.m./p.m.

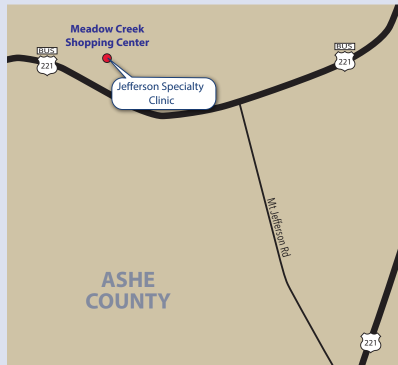
☐ Boone, NC ☐ West Jefferson, NC ☐ Linville, NC

To reschedule your appointment, please call (828) 264-9664.

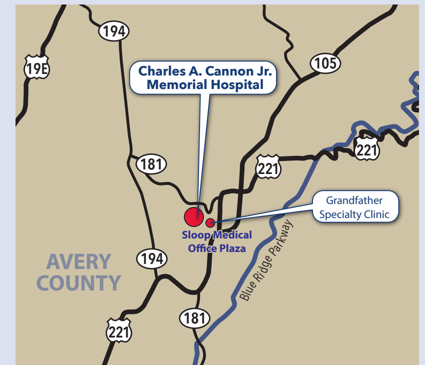
To learn about the providers at this location, visit *apprhs.org*



336 Deerfield Road
Boone, NC 28607



968 Hwy 221 Business
West Jefferson, NC 28694



436 Hospital Drive
Linville, NC 28646

HEART & VASCULAR CENTER of **WATAUGA MEDICAL CENTER**	Patient Name________________________________ Date of Birth________________________________ MRUN Number________________________________ Please Fill in or Affix a Patient Label

☐ **New Patient Information** ☐ **Reestablishing Patient Information** Date: __________

Patient Name: ______________________________ Age: _______ ☐ Female ☐ Male

City/State: ______________________________

Primary Physician: ____________________ Physician's Phone Number: ____________

Height: _______ Weight: _________ BMI: _________ Pulse: _________ O2: _________

Blood Pressure: Supine Right ____________ Left ____________

Standing Right ____________ Left ____________

Chief Complaint ______________________________

Date of: _________ Last Cholesterol: _________ Trig: _________ HDL: _________ LDL: _________

In the past 4 weeks have you had any problems with balance or falling? ☐ YES ☐ NO ☐ Non-ambulatory

In the last year have you fallen 2 or more times or had a fall with injury? ☐ YES ☐ NO ☐ Non-ambulatory

Do you have any of the following symptoms? ☐ Chest Pain ☐ SOB ☐ Palpitations ☐ Fall within last 6 months

History of Present Illness

____

____

____

____

____

____

____

____

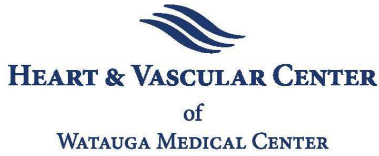
____

Follow up treatment plan:

☐ Patient recommended to follow-up with primary care provider.
☐ Recommend referring patient to PT/OT for balance/gait/strength
☐ Advise patient to remove trip hazards
☐ Reviewed medications that could increase fall risk
☐ Recommended Vitamin D supplements daily
☐ Patient declines the referral recommended above

Provider Signature ▶	Date: Time:
Provider Name *(Please Print)* ▶	

Effective Date: Not Set
Revised Date: 08/03/2020

 HEART & VASCULAR CENTER of WATAUGA MEDICAL CENTER	Patient Name________________________________ Date of Birth________________________________ MRUN Number_________________________________ Please Fill in or Affix a Patient Label

Patient Last Name	**Middle Name**	**First Name**	**Account #**

Medical History

Have you ever had high blood pressure? ☐Yes ☐No For how long? __________ Current Treatment: ________________

Have you ever had high cholesterol? ☐Yes ☐No For how long? __________ Current Treatment: ________________

Do you know the number of your last cholesterol reading? ☐Yes ☐No Triglycerides: _______ HDL: _______ LDL: ______

Do you have or have ever had diabetes? ☐Yes ☐No For how long? _________ Current Treatment: _________________

Have you ever smoked? ☐Yes ☐No

☐Cigarettes: Packs per day ________ Number of Years ________ Quit Date ___________

☐Cigars: Packs per day ________ Number of Years ________ Quit Date ___________

☐Pipe: Amount ________ Number of Years ________ Quit Date ___________

Please list all medications that you are taking including the dose and schedule, including aspirin and vitamins.

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Have you ever had a reaction to x-ray dye? ☐Yes ☐No When and where?_______________________________

What kind of reaction to x-ray dye did you have? ____

List any food, drug, or season allergies:

1. ____________________________________ Type of Reaction: _____________________________________
2. ____________________________________ Type of Reaction: _____________________________________
3. ____________________________________ Type of Reaction: _____________________________________

Please list all surgeries you have had:

Date	Surgery	What hospital?

HEART & VASCULAR CENTER of WATAUGA MEDICAL CENTER	Patient Name________________________________ Date of Birth________________________________ MRUN Number________________________________ Please Fill in or Affix a Patient Label

Have you ever had any other major medical problems that required hospitalization? (Accidents, Cancer Radiation treatment, chemotherapy, etc.)

Date	Length of Stay	Hospital	Reason for Admission

Do you have any other major medical problems that have not required hospitalization?

____

____

____

____

Family History

	Age if Living	Health good/bad	Age at Death	High Blood Pressure?	Stroke?	Angina?	Heart Attack?	Kidney Disease?	Comments
Father				☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
Mother				☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
Sisters 1				☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
2				☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
3				☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
4				☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
Brothers 1				☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
2				☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
3				☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
4				☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	

Does anyone on your mother's side of the family have heart disease or diabetes? ☐Yes ☐No

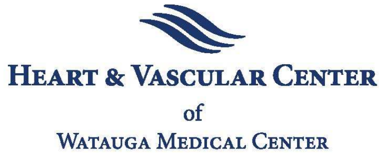
Does anyone on your father's side of the family have heart disease or diabetes? ☐Yes ☐No

Social/Personal History

☐Married ☐Widowed ☐Single ☐Divorced

Your occupation ____________________________________ Past Occupation? ____________________________________

Have you ever had industrial exposure? (cotton dust, Asbestos, Benzene or other) ☐No ☐Yes ____________________________

	Patient Name________________________________ Date of Birth________________________________ MRUN Number________________________________ Please Fill in or Affix a Patient Label

Social History Cont…

Spouse or significant others name _______________________________ Age________ Health __________________________

Occupation of spouse or significant other ____

Number of children ____________ their ages___________________ Health ____

How many living at home? ____________

Military Service ____

What is your height? ____________ Current weight ____________ Greatest weight _____________ Lowest ______________

Do you ever drink the following?

☐Coffee: Cups per day ____________ ☐Tea: Glasses per day _____________ ☐Colas: Glasses per day _____________

☐Alcohol: Type _____________ Amount per day _____________

Have you ever used drugs? ☐No ☐Yes What type? _____________________________________Quit Date _______________

How did you hear about us?

☐Billboards ☐Doctor ☐Friends/Family ☐Magazine ☐Newspaper ☐Social Media ☐Radio ☐TV

☐ARHS Website ☐Other________________________

Review of Systems

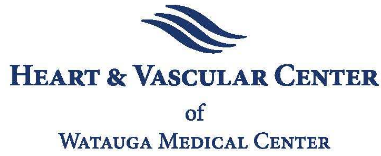
Please check if you have had any of the following:

	Past	Present		Use space below for explanation
Skin:			Bruising	
			Long Term Skin Disease	
Extremities:			Numbness	
			Swelling	
			Arthritis/painful joints	
			Back trouble	
			Leg Cramps	
			Leg Cramps with exercise	
Head:			Headaches	
			Dizziness	
			Concussion	
			Fainting Spells	
Ears:			Ringing in Ears	
			Bleeding or discharge from ears	
			Impaired hearing	
Eyes:			Impaired vision	
			Cataracts	
			Glaucoma	
Nose:			Nosebleeds	

Heart:				
			Rheumatic fever	
			Heart murmur	
			Heart attack	
			Congestive heart failure	
			Enlarged heart	
			Chest pain	
			Irregular heartbeat	
			Pacemaker	

	Past	Present		Use space below for explanation
Respiratory:			Hoarseness	
			Cough	
			Cough up any blood	
			Short of breath	
			Pneumonia	
			Wheezing	
			Asthma	
			Hay fever	
			Bronchitis	
			Emphysema	
			Tuberculosis	
			Pleurisy	
GI:			Difficulty swallowing	
			Recent weight change in the last 6 mos.	
			Hiatal hernia	
			Ulcer	
			Heartburn	
			Liver disease	
			Hemorrhoids	
			Constipation	
			Rectal Bleeding	
			Blood in the stool	
			Diarrhea	
			Hepatitis	
			Abdominal pain	
			Vomited blood	
			Upper GI series: When: ____________________ Body Part: __________________________ Results: ____	
			Gallbladder x-ray: When: ____________________ Body Part: __________________________ Results: ____	
			Endoscopy: When: ____________________ Body Part: __________________________ Results: ____	

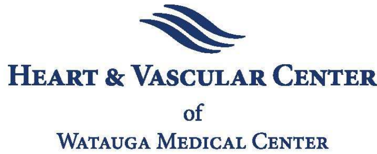
GU			Blood in urine	



Patient Name_______________________________
Date of Birth_______________________________
MRUN Number_______________________________
Please Fill in or Affix a Patient Label

			Kidney stones	
			Kidney infection	
			Difficulty or pain with urination	
			Frequency in urination	
			Sexually Transmitted Disease (STD)	
			Bladder problem	
			Waking up at night to urinate	

	Past	Present		Comments
Neuromuscular:			Convulsions	
			Stroke	
			Depression	
			Anxiety	
			Eating disorder	
			Chronic Pain	
Endocrine:			Hormone Imbalance	
			Hormone Supplements	
			Thyroid trouble	
Hematology			Anemia	
			Blood transfusion	
			Blood disorder	
			Phlebitis	

	Patient Name________________________________ Date of Birth________________________________ MRUN Number________________________________ Please Fill in or Affix a Patient Label

Authorization of Release of Medical and/or Financial Information

Persons authorized to receive information:

1. Name: ____________________________ Relationship: __________________ Phone #: ______________________
2. Name: ____________________________ Relationship: __________________ Phone #: ______________________
3. Name: ____________________________ Relationship: __________________ Phone #: ______________________
4. Name: ____________________________ Relationship: __________________ Phone #: ______________________

Please indicate information that can be released:	How may we leave messages for you?
☐ Medical (i.e. results of lab tests / x-rays	☐ Voicemail: ______________________________________
☐ Appointment Information	☐ E-mail: ______________________________________
☐ Financial	☐ Other: ______________________________________
☐ Other	

Signature Page

- All of my registration information is true and accurate to the best of my knowledge.
- I acknowledge that I received and understand the Financial Agreement.
- I acknowledge that I receive the Release of Medical and/or Financial information.
  I understand that I have the right to revoke this authorization at anytime.
  Revocation must be made in writing and will be effective from date of revocation.
- Assignment of Benefits
  (Only pertains to those with insurance we are filing.)

I hereby assign to The Heart and Vascular Center of Watauga Medical Center any insurance or other third-party benefits available for healthcare services provided to me. I understand that The Heart and Vascular Center of Watauga Medical Center has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to The Heart and Vascular Center of Watauga Medical Center Healthcare system, I agree to forward the Practice all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian	Date	Time
Signature of Guarantor	Date	Time
Description of Personal Representative's Authority: (*attach necessary documentation*)		