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Awais K. Humayun, MD, FACC, FHRS

Patient Registration Form (Please Print)

Patient Legal Name (First):_____ (Last):_____ Date:___/____/____

Biological Gender: ❒ M ❒ F ❒ Ask Me Pronouns:_____ DOB:___/____/____

Gender Identity:_____ Height:_____ Weight:_____

Status: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed ❒ Other:_____

Race: ❒ American Indian or Alaska Native ❒ Asian ❒ Black or African American ❒ White
❒Hispanic or Latino ❒ Native Hawaiian or Other Pacific Islander ❒ Unknown ❒ Other:_____

Ethnicity: ❒ Hispanic or Latino ❒ Not Hispanic or Latino

Preferred Language: ❒ English ❒ Spanish ❒ ASL ❒ Other_____

Do you have a living will? ❒ No ❒ Yes: Please provide a copy to the front desk

Address: _____

City/State:_____ Zip Code:_____ Country: _____

Primary Phone: (___)_____ OK to Leave Voicemail? ❒ Yes ❒ No

Mobile phone: (___)_____ ←OK to call? ❒ Yes ❒ No | Voicemail OK? ❒ Yes ❒ No

Would you like to receive automated-text messages from HRS? ❒ No ❒ Yes, Standard Rates Apply

Email Address: _____

Primary Care Provider (PCP): _____

PCP Phone: (___)_____ PCP Fax: (___)_____

PCP Address: _____

Work Status: ❒ Full-Time ❒ Part-Time ❒ Student ❒ Retired ❒ Unemployed ❒ Other:_____

Employer's Name: _____

Work Phone: (___)_____ ←OK to call? ❒ Yes ❒ No

Employers Address:_____

Patient Insurance Information

Responsible Party: ❒ Self ❒ Family Member's Ins. ❒ Another Party ❒ Guarantor ❒ Other:_____

Relationship to Subscriber: ❒ Self ❒ ***Spouse** ❒ ***Child** ❒ ***Other:**_____

Check here if Subscriber address and telephone information is same as the Patient ❒

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Patient Registration Form (Please Print)

Patient Legal Name (First): _____ (Last): _____ Date: ___/____/____

Primary Insurance Carrier: _____ Ins. Co. Phone: (___) _____

Group Number: _____ Policy Number: _____ Start Date: _____

Insurance Type: ❒ HMO ❒ PPO ❒ Open Access ❒ Other: _____

PCP Referral Required? ❒ Yes ❒ No Specialist Copay: _____ Deductible: _____

***If relationship is Spouse, Child, or Other, also enter Subscriber information:**

Subscriber's First Name: _____ Last: _____ DOB: ___/___/____

Subscriber's Street Address: _____

City/State: _____ Zip Code: _____ Country: _____

Subscriber's Phone: (___)_____ Voicemail OK? ❒ Yes ❒ No Subscriber's Sex: ❒ M ❒ F

Secondary Insurance (*enter NA for not applicable*)

Secondary Insurance Carrier: _____ Ins. Co. Phone: (___) _____

Group Number: _____ Policy Number: _____ Start Date: _____

Secondary Insurance Type: ❒ HMO ❒ PPO ❒ Open Access ❒ Other: _____

Relationship to Subscriber: ❒ Self ❒ *Spouse ❒ *Child ❒ *Other: _____

PCP Referral Required? ❒ Yes ❒ No Specialist Copay: _____ Deductible: _____

***If relationship is Spouse, Child, or Other, also enter Subscriber information:**

Check here if Subscriber address and telephone information is same as the Patient ❒

Subscriber's First Name: _____ Last: _____ DOB: ___/___/____

Subscriber's Street Address: _____

City/State: _____ Zip Code: _____ Country: _____

Subscriber's Phone: (___)_____ Voicemail OK? ❒ Yes ❒ No Subscriber's Sex: ❒ M ❒ F

Referral Information (Required)

Patient's Referring Provider: _____

Patient's Referring Provider Address: _____

Telephone: (___) _____ Fax: (___) _____

Patient's Cardiologist: _____ Telephone: (___) _____

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Patient Registration Form (Please Print)

Patient Legal Name (First): _____ (Last): _____ DOB: ___/___/___

Cardiologist's Address: _____

Preferred Pharmacy (Required)

Patient's Pharmacy: _____ Pharmacy Phone: (___)_____

Pharmacy Address: _____

Diagnosis (*If Pregnant: Add "Pregnant" & Number of Months*)

Diagnosis: 1. _____ Diagnosis: 6. _____

Diagnosis: 2. _____ Diagnosis: 7. _____

Diagnosis: 3. _____ Diagnosis: 8. _____

Diagnosis: 4. _____ Diagnosis: 9. _____

Diagnosis: 5. _____ Diagnosis: 10. _____

Recent Hospitalizations

Recent Hospitalization? ❒ Yes ❒ No Date of last physical exam: _____

Reason(s): _____

Hospital/Facility: _____ Dates: _____

Cardiac Device History

Existing Cardiac Device? ❒ No ❒ Yes Device Type: _____

Manufacturer: ❒ Medtronic ❒ St. Jude/Abbott ❒ Boston Scientific ❒ Biotronik ❒ Sorin/ELA ❒Unknown

Emergency Contact

In Case of Emergency (ICE) Person: _____ Phone: (___)_____

Relationship: _____ Mobile: (___)_____

Address: _____

General Patient Consent: I give permission for Heart Rhythm Solutions (HRS) | Awais K. Humayun, MD, FACC, FHRS to provide medical treatment and to file for insurance benefits to pay for the care I receive. I understand that: HRS will send my healthcare information to my insurance company for the purposes of treatment, payment, or healthcare operations. I must pay for the cost of services if my insurance does not pay, or if I do not have insurance. I must pay my share of insurance costs (co-pays, deductible, non-covered services, etc). I have the right to discuss all medical treatments with my physician, and to refuse any procedure or treatment.

Patient Signature (Required)

Signature of Patient (or Legal Representative): _____ **Date:** ___/___/___

Printed Name of Legal Representative: _____ **Date:** ___/___/___

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Patient Registration Form (Please Print)

Patient Medical & Family History Questionnaire

Patient Name (First): _____ (Last): _____ DOB: ____/____/____

Reason for Visit: _____

Immunizations/Dates: ❒ Hep B: _____ ❒ Influenza: _____ ❒ Meningococcal: _____ ❒ Tetanus: ❒

Others: _____

Previous Surgeries

❒ CABG (Coronary Bypass) ❒ Valve Replacement ❒ Cardiac Device ❒ Ablation
❒ Gallbladder ❒ Tonsillectomy ❒ Appendectomy ❒ Hernia
❒ Other: _____

Current Medical Conditions

❒ Chest Pain ❒ Bleeding Disorder ❒ Heart Attack ❒ Heart Disease
❒ Hypertension ❒ Diabetes ❒ Cancer ❒ Kidney Disease
❒ Liver Disease ❒ Lung Problems ❒ Joint Disease ❒ Psychiatric Disorder
❒ Sleep Disorder ❒ Thyroid Disorder ❒ Skin Disease ❒ Stroke
❒ Glaucoma ❒ Ulcer ❒ Other: _____ ❒ I'm Pregnant: ____ Wks.

Tobacco Use: ❒ Never ❒ Previous ~Start: _____ ~End Date: _____

❒ Current ➡Amount: _____ Pack/Wk Other Frequency: _____

Alcohol Use: ❒ Never ❒ Previous ~Start: _____ ~End Date: _____

❒ Current ➡ Amount: _____(ounces) per Day / Week / Month (Circle) *Other* Frequency: _____

Illicit drug use in last 3-to 6-mo. (e.g., cocaine, heroin, methamphetamine, crack)? ❒ **Yes (Circle)** ❒ **No**

Family History

Is There a Family History of: ❒ Heart Attack ❒ Bypass Surgery ❒ Heart Rhythm Problems
❒ Heart Disease ❒ Cardiac Arrest ❒ Unexplained Fainting ❒ Other: _____

Father: ❒ Alive & Age: _____ ❒ Deceased at Age: _____ Due to: _____

Medical Problems: _____

Mother: ❒ Alive & Age: _____ ❒ Deceased at Age: _____ Due to: _____

Medical Problems: _____

Number of Siblings: _____ Medical Problems: _____

Number of Children: _____ Medical Problems: _____

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Patient Registration Form (Please Print)

Medication & Allergies Information

Name (First): _____ (Last): _____ DOB:____/____/____

Pharmacy Name: _____ Phone: ( ) _____ Fax: ( ) _____

Pharmacy Address: _____

List allergic reactions to medications & other allergies that may affect your care.

Medication Allergies	Reaction

Include OTC, vitamins and other supplements, as well as alternative and herbal medications/tinctures

Medication & RX Start Date	Dosage	Frequency

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Patient Registration Form (Please Print)

Review of Systems | Please check all that apply

Name (First): _____ (Last): _____ DOB:___/___/___

General

- ❑ Chronic Pain: _____
- ❑ Chills, Shakes
- ❑ Excessive Daytime Sleepiness
- ❑ Easy/Prolonged Bleeding
- ❑ Fatigue: _____
- ❑ Fevers
- ❑ Immunocompromised (specify): _____

_____

- ❑ Lethargy / Low Energy
- ❑ Malaise
- ❑ Medication and/or Medical Dye Sensitivities
- ❑ Sleeping Difficulties: _____
- ❑ Other: _____

Eyes

- ❑ Blurred Vision
- ❑ Cataracts
- ❑ Double Vision / Visual Disturbance
- ❑ Drainage from Eyes
- ❑ Flashing Lights, Specks, Other
- ❑ Glaucoma
- ❑ Itchy Eyes
- ❑ Redness / Irritation
- ❑ Vision Loss/changes
- ❑ Wears Glasses/Contacts

Ears

- ❑ Deafness
- ❑ Diminished Hearing
- ❑ Ear Discharge / Drainage
- ❑ Ear Pain
- ❑ Ear Fullness
- ❑ Itching in Ear
- ❑ Pressure Sensation
- ❑ Tinnitus (Ringing, Buzzing)
- ❑ Unusual Sounds
- ❑ Vertigo

Endocrinology

- ❑ Excessive Sweating
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Hair Loss / Excessive Growth
- ❑ Significant Heat and/or Cold Intolerance
- ❑ Other: _____

Cardiac

- ❑ Chest Pain: _____
- ❑ Chest Tightness
- ❑ Cyanosis (bluish, purplish cast of skin/mucous membranes)
- ❑ Difficulty laying flat
- ❑ Dizzy upon standing and/or Dizzy Spells
- ❑ Edema
- ❑ Fainting Spells / Syncope
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Irregular Heartbeat
- ❑ Murmor
- ❑ Palpitations
- ❑ Rapid Heart Rate
- ❑ Shortness of Breath w/Activity (Dyspnea on Exertion)
- ❑ Swelling Ankles
- ❑ Waking Up Gasping for Air
- ❑ Varicose Veins
- ❑ Other: _____

Gastrointestinal: _____

- ❑ Abdominal Pain
- ❑ Acid Reflux and /or Heartburn
- ❑ Bright Blood in Stool
- ❑ Black/Tarry Stools
- ❑ BM Accidents
- ❑ Change in Bowel Habits
- ❑ Constipation
- ❑ Diarrhea

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Patient Registration Form (Please Print)

Gastrointestinal (Continued)

- ❑ Food Allergies
- ❑ Nausea OR Vomiting (circle one or both)
- ❑ Poor Appetite / Change in Appetite
- ❑ Unexplained or New Weight Gain / Loss

Genitourinary-Female

- ❑ Abnormal Discharge
- ❑ Dysmenorrhea
- ❑ Frequent Yeast Infections
- ❑ Infertility
- ❑ Intermenstrual Bleeding
- ❑ Irregular Periods
- ❑ Menopause
- ❑ Pain with Sexual Activity
- ❑ Pelvic Pain
- ❑ Premenstrual Syndrome
- ❑ Vaginal Itching
- ❑ Other: _____

Genitourinary-Male

- ❑ Abnormal Discharge
- ❑ Infertility
- ❑ Trouble with Erection
- ❑ Pain with Sexual Activity
- ❑ Penile Lumps / Hernias
- ❑ Prostate Cancer
- ❑ Scrotal Pain / Swelling
- ❑ Other: _____

Kidneys

- ❑ Kidney Disease (specify): _____
- ❑ Kidney Stones
- ❑ Other: _____

Lungs / Respiratory

- ❑ Allergies
- ❑ Asthma
- ❑ Chronic or New Cough
- ❑ Coughing Up Blood
- ❑ Pain with Deep Breaths
- ❑ Shortness of Breath
- ❑ Sputum (mucus or phlegm)
- ❑ Wheezing

Lungs / Respiratory

- ❑ Breathing Problems: _____
- ❑ Other: _____

Mouth, Nose, Throat

- ❑ Bleeding Gums
- ❑ Decreased Sense of Smell
- ❑ Dentures
- ❑ Dry Cough
- ❑ Dry Mouth
- ❑ Difficulty Swallowing
- ❑ Frequent Throat Clearing
- ❑ Gums Bleeding
- ❑ Hoarseness / Change in Voice
- ❑ Lump in Throat Sensation
- ❑ Mouth Pain
- ❑ Nasal Obstruction
- ❑ Nasal Discharge / Drainage
- ❑ Nasal Congestion
- ❑ Nasal Pain
- ❑ Neck Tenderness
- ❑ Nose Bleeds
- ❑ Poor Dentition
- ❑ Postnasal Drip
- ❑ Runny nose
- ❑ Scratchy Throat
- ❑ Sinus Pain / Headaches
- ❑ Sneezing
- ❑ Snoring
- ❑ Sores
- ❑ Sore Tongue
- ❑ Sore Throat
- ❑ Swollen Glands

Musculoskeletal / Joints

- ❑ Back Pain
- ❑ Difficulty Walking
- ❑ Gait Problems
- ❑ Limitation of Motion
- ❑ Leg Pain While Walking
- ❑ Muscle Cramps (where?): _____
- ❑ Muscle Aches / Pain (Myalgia)

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Patient Registration Form (Please Print)

Musculoskeletal / Joints (Continued)

- ❑ Muscle Weakness
- ❑ Neck Pain
- ❑ Neck Stiffness
- ❑ Joint Pain (Arthralgia): _____
- ❑ Joint Redness
- ❑ Joint Stiffness: _____
- ❑ Joint Swelling
- ❑ Joint Trauma
- ❑ Shoulder Pain
- ❑ Unusual Warmth
- ❑ Other: _____

Mental Health: _____

- ❑ Addiction (Current, Recovery, Other (circle one)
- ❑ ADHD
- ❑ Adverse Childhood Experiences
- ❑ Bipolar Disorder
- ❑ Eating Disorder
- ❑ Exceptional Stress
- ❑ Frequently Agitated / Irritated
- ❑ Frequent Anger
- ❑ Decreased Concentration
- ❑ Hallucinations (when?): _____
- ❑ Major Depression (or History)
- ❑ Memory Loss
- ❑ Mood Change / Swings
- ❑ Nervous/Anxious
- ❑ Obsessive Compulsive Disorder or Tendencies
- ❑ Post-Partum Depression
- ❑ PTSD
- ❑ Self-Injury
- ❑ Severe Anxiety (or History)
- ❑ Situational Anxiety
- ❑ Other: _____

Neurologic: _____

- ❑ Arm/Leg Weakness
- ❑ Confusion
- ❑ Dizziness or Lightheadedness
- ❑ Epilepsy, Seizures, or History of Seizures
- ❑ Falls

Neurologic

- ❑ Fainting / Loss of Consciousness
- ❑ Head Injury / Concussion (or History)
- ❑ Involuntary Movements/Jerking
- ❑ Migraines
- ❑ Nerve Pain / Pinched Nerves
- ❑ Numbness (where): _____
- ❑ Significant Memory Loss
- ❑ Speech Difficulty
- ❑ Stroke: _____
- ❑ Tingling: (where): _____
- ❑ Tremor
- ❑ Trouble Speaking
- ❑ Unsteady Gait
- ❑ Spinning Sensation
- ❑ Weakness (where): _____

Skin/Integumentary: _____

- ❑ Allergies
- ❑ Blistering
- ❑ Cancer
- ❑ Disorders (e.g., acne, eczema, psoriasis, vitiligo)
- ❑ Gland Disorders
- ❑ Easy Bruising
- ❑ Frequent Itchiness
- ❑ Fungal Infections
- ❑ Infections
- ❑ Lumps / Masses
- ❑ Moles
- ❑ Nail Disorders
- ❑ Rashes: _____
- ❑ Slow Healing after cuts/wounds

Urologic

- ❑ Burning /OR/ Pain with Urination (circle one or both)
- ❑ Blood in Urine
- ❑ Difficulty Urinating / Decrease in Frequency
- ❑ Frequent Urination
- ❑ Pain from Bladder Around to Back
- ❑ Urgent Urination
- ❑ Urinary Incontinence
- ❑ Other Bladder Problems: _____

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Additional Medical Conditions

4801 S University Drive, Suite 104 | Davie, Florida 33328 | P: (954) 707-5200 | F: (954) 526-4562 | heartrhythmsolutions.com

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Awais K. Humayun, MD, FACC, FHRS

Patient Registration Form (Please Print)

GENERAL CONSENT FOR CARE AND TREATMENT

I give permission for Heart Rhythm Solutions | Awais K. Humayun MD PA to provide medical treatment and to file for insurance benefits to pay for the care I receive.

You have the right to be informed about your condition and recommended diagnostic tests, treatments, or surgical procedures to be used in your care. Plainly explaining recommendations with their associated benefits and risks is required so that you can make informed decisions to undergo or not undergo any suggested test, treatment, or procedure. At this point in your care, no specific treatment plan has been recommended.

You have the right to discuss your treatment plan with your physicians and ask questions about the purpose, potential risks, and benefits of any test ordered for you. This consent provides us with permission to perform reasonable and necessary medical exams, evaluations, and testing necessary to identify appropriate treatments and/or procedures for any identified condition(s). By signing below, you are indicating that: (a) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and, (b) you consent to treatment at this office, or any other HRS office / setting and /or affiliated hospital or medical facility. The consent will remain effective until it is revoked in writing. You have the right to discontinue services at any time. **Please check all that apply:**

- ☐ I voluntarily request Awais K. Humayun, MD, FACC, FHRS to perform any reasonable and necessary medical exams, testing, and treatment for the condition that has brought me to seek care at HRS.
- ☐ I voluntarily request a mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), to perform reasonable and necessary medical exams, testing, and treatment for the condition that brought me to seek care at HRS.
- ☐ I voluntarily request health care providers at Heart Rhythm Solutions, or their designees as deemed necessary, to perform reasonable and necessary medical exams, testing, and treatment for the condition that brought me to seek care at HRS.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Patient Name (Print)	**Date**
Patient Signature	**Date of Birth**
PRINT (Legal Representative for Patient)	**Relationship to Patient**
Signature (Legal Representative for Patient)	**Date**