"Ed" Gandhi, MD, FACC
Ph (813) 689-1912

511 Medical Oaks Ave
Brandon, Fl 33511

CARDIOLOGY & VASCULAR

Adithya K Gandhi, MD, PLC

Welcome!

Thank you for trusting me with your healthcare. I promise to provide you with the finest care available. The information on this cover sheet answers common questions our patients have. I hope you will find this information helpful and reassuring. Should you have any further questions, please do not hesitate to call the office. I look forward to seeing you in the office soon!

It is **VERY IMPORTANT** that you fill out the enclosed forms before your visit. Upon completion, you may bring them with you to your appointment.

Bring your **INSURANCE CARD(S)** with you for every visit. We will scan them before your first visit and check for any changes each visit thereafter. Please notify the front desk of **ALL** insurance and demographic changes before your visit so that our files are current.

If your insurance requires a **CO-PAY** for a specialist visit, payment is due at time of check in. We accept cash, check and all major credit cards. Please be aware that a **CO-PAY/CO-INSURANCE/DEDUCTIBLE** may be required for **ALL** visits, including testing appointments. We understand that you may have to come for multiple tests and an office visit for results and apologize for any hardship this may cause, however it **IS NOT** our requirement, it is your insurance companies requirement that payment is made EACH time you come to the office.

It is **YOUR RESPONSIBILITY** to obtain a **REFERRAL** from your primary care physician, if it is required by your insurance. Please bring it with you to your appointment. If we do not have your referral, *WE WILL NOT BE ABLE TO SEE YOU due to insurance requirements.*

Please bring a **LIST OF ALL MEDICATIONS** you are currently taking to every visit. If you have had recent labs, EKG, echo or stress test please bring a copy of the reports with you to your visit.

Thank you for your cooperation. And again, if you have any questions, feel free to contact our office.

Sincerely,

Dr. Gandhi & Staff

Adithya "Ed" K. Gandhi, PLC

AS A COURTESY TO OUR PATIENTS, OUR OFFICE WILL FILE YOUR INSURANCE

DATE _____/_____/_____ **PRIMARY CARE PHYSICIAN**_____

NAME _____ **MALE / FEMALE**

RACE _____ **LANGUAGE** _____ **ETHNICITY:** HISPANIC / NOT HISPANIC

E-MAIL ADDRESS: (PRINT CLEARLY)_____

SOCIAL SECURITY # _____ **BIRTHDATE** _____/_____/_____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

PHONE # _____**PREFERRED #: YES / NO MAY WE LEAVE MESSAGE:** YES / NO

CELL # _____**PREFERRED #: YES / NO MAY WE LEAVE MESSAGE:** YES / NO

EMPLOYER _____

WORK # _____ **MAY WE LEAVE MESSAGE:** YES / NO

SINGLE / MARRIED / DIVORCED / WIDOWED

SPOUSE NAME _____

CELL # _____ **MAY WE LEAVE MESSAGE:** YES / NO

PRIMARY INSURANCE HOLDER _____

NEAREST RELATIVE NOT LIVING WITH YOU _____

PHONE # _____ **MAY WE LEAVE MESSAGE:** YES / NO

DO YOU RESIDE ANYWHERE ELSE DURING THE YEAR: YES / NO

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

PHONE # _____ **MAY WE LEAVE MESSAGE:** YES / NO

_____

PATIENT SIGNATURE

"Ed" Gandhi, MD, FACC
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511 Medical Oaks Ave
Brandon, Fl 33511

CARDIOLOGY & VASCULAR

Adithya K Gandhi, MD, PLC

DATE _____

TO _____

_____

_____

_____

I request that a copy of my medical records be released to:

_____ **Ed Gandhi, M.D.**

Please send to: **Adithya K. Gandhi, PLC**
511 Medical Oaks Ave
Brandon, Fl 33511
Fax (813) 684-3335

Hospital Record Requests:
Unless otherwise stated please send most recent EKG strip, H&P, D/C summary, echo, stress test and all cardiac catheterizations, PTCA's and CABG's.

In addition, I also authorize Dr. Gandhi to provide copies of my results to my referring physician as noted in my records.

A copy or fax of this authorization may be used in lieu of the original.

_____ _____
Patient Name (PRINT) **Date of Birth**

_____ _____
Patient Signature **Social Security # (last 4)**

Adithya "Ed" K. Gandhi, PLC

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment (including but not limited to HIV/HEP reports). I understand that this information serves as:

*A basis for planning my care and treatment
*A means of communication among the health professionals who contribute to my care
*A source of information for applying my diagnosis and treatment information to my bill
*A means by which a third-party payer can verify that services billed were actually provided
*A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff
*I authorize A.K. Gandhi, PLC to download my medication history and prescription benefits

I have been provided the opportunity to review "Notice of Patient Information Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

*The right to review the "Notice" prior to acknowledging this consent
*The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
*The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

Restrictions:

I request the following restrictions to the use or disclosure of my health information:

_____
_____
_____

May discuss treatment, payment or healthcare operation with the following persons:

Please check all that apply: spouse ( ) children ( ) parents ( ) others ( )

Please list names: _____
_____
_____
_____

I understand that as part of treatment, payment or healthcare operation, it may become necessary to disclose health information to another entity. Examples: referrals to other healthcare providers, labs and/or other individuals or agencies as permitted or required by state or federal law.

I fully understand and accept the information provided by this consent.

_____ _____ _____

Signature Print Name Date

*If person other than patient is signing, are you: Parent, legal guardian, custodian or have power of attorney

yes ( ) no ( )

FOR OFFICE USE ONLY

( ) Patient refused to sign consent form

Adithya "Ed" K. Gandhi, PLC

Name _____ Date _____
DOB _____ Height _____ Weight _____
Referred by (circle one): hospital / family or friends / insurance / first available / previous patient /
Web search: _____ / physician: _____ / other: _____
When was the last EKG _____ Last stress test _____
What pharmacy do you use _____ Location _____

Do you have a history of:

Heart Disease	Yes / No	Murmur	Yes / No	Chest Pain / Angina	Yes / No
Palpitations	Yes / No	Sleep Apnea	Yes / No	Shortness of Breath	Yes / No
Heart Attack	Yes / No	When _____		Where _____	
Heart Cath	Yes / No	When _____		Where _____	
Angio / Stent	Yes / No	When _____		Where _____	
Bypass Surgery	Yes / No	When _____		Where _____	
Pacer / Defib	Yes / No	When_____		Where _____	

Adult Illnesses:

High Cholesterol	Yes / No	Stroke / Paralysis	Yes / No	High Blood Pressure	Yes / No
Arthritis	Yes / No	Cardiomyopathy	Yes / No	Congestive Heart Disease	Yes / No
Thyroid Disease	Yes / No	Hepatitis	Yes / No	Diabetes	Yes / No
Cancer	Yes / No	Asthma / COPD	Yes / No	Epilepsy / Seizures	Yes / No

Surgeries:

Year _____ Reason _____ Hospital _____
Year _____ Reason _____ Hospital _____
Year _____ Reason _____ Hospital _____
Year _____ Reason _____ Hospital _____

Family History:

Father	Living _____	Age _____	Heart Disease Yes / No	_____
	Deceased _____	Age _____	Cause of Death	_____
Mother	Living _____	Age _____	Heart Disease Yes / No	_____
	Deceased _____	Age _____	Cause of Death	_____

Social History:

Do You Smoke	Yes / No	How Much _____	Current Illegal Drug Use _____
Have You Ever Smoked	Yes / No	When Did You Quit _____	Past Illegal Drug Use _____
Do You Drink Alcohol	Yes / No	How Much _____	Caffeine Intake _____

Medications: Name	Strength	How Often

Allergies to Medications _____

Adithya "Ed" K. Gandhi, PLC

PVD/PAD Screening Form

Name_____DOB_____ Date_____

If you have lower extremity pain, please describe:

Location (buttocks, thighs, knees, feet): _____

Timing (Continuous, occasional, episodic):_____

DO YOU EXPERIENCE ANY OF THE FOLLOWING?		Comments
1. Leg cramping?	Y / N	_____
2. Numb/cold/pale feet?	Y / N	_____
3. Pain when leg is elevated and improves when leg is dangled?	Y / N	_____
4. Symptoms relieved with rest and start during exercise?	Y / N	_____
5. Decreased ability to walk for any reason?	Y / N	_____
6. Leg heaviness/tiredness/fatigue?	Y / N	_____
7. Itching/burning/red/hot/swollen/throbbing legs?	Y / N	_____
8. Have your veins gotten worse in recent months?	Y / N	_____
9. Have you ever had a blood clot in your legs or phlebitis?	Y / N	_____
10. Do you use any type of compression/support hose?	Y / N	_____
Do they provide relief?	Y / N	
11. Are you taking any pain medicine?	Y / N	_____
What type and how often?		_____
12. Are you taking any iron supplements or Vitamins with iron?	Y / N	_____
13. Have you ever had your veins evaluated before?	Y / N	_____
Where and when?		_____
14. Painful/nonbleeding ulcers on feet or toes?	Y / N	_____