General Information

We are pleased you have taken this step to take a proactive role in your health with us. We are a concierge style practice devoted to your arterial health. The goal of preventing an atherosclerotic event, involves your active participation in the treatment plan devised by Dr. Goulder. We will be working with your current medical/dental team to accomplish this goal of vascular health. Since we are confident that with your participation we can prevent heart attacks and strokes, we guarantee our results. If you suffer a heart attack or stroke resulting from atherosclerosis, we will refund your fees for that calendar year. This includes atherosclerotic events not embolic or hemorrhagic events. Naturally, you will still need the care of your primary care physician/dentist for your other medical conditions.

Although we are a “fee for service center," after each office visit we will provide you with a universal claim form to submit to your insurance for possible reimbursement. Be familiar with your medical plan so that you are aware of your out-of-pocket expenses.
NOTE: Claims cannot be submitted to Medicare as this is a non-contracted center.

Membership with our care center is renewed annually. Please make sure to review our pricing model. If you have additional questions, please contact our office prior to your appointment.

Blood work and other testing may be covered by your health insurance carrier. Please bring your current insurance card with you to your appointment. We will provide outside facilities with this information so they can bill your insurance carrier directly. Laboratory testing is an integral part of our risk assessment. Be aware that medical coverage may vary. Please be familiar with your plan.

We appreciate 4 weeks’ notice if you are unable to keep your initial risk assessment appointment.

We appreciate 72 hour notice if you are unable to make a scheduled appointment.

We accept cash, check, Visa, MasterCard and American Express.

Patient Understanding of Initial Risk Assessment Payment

The total fee of your comprehensive risk assessment and delivery of management plan is: $2,500.

At the time your appointment is set, a non-refundable deposit of $500 is due to hold your appointment. Your $500 deposit applies towards your total risk assessment fee.

Your balance of $2,000 is due in our office two (2) weeks prior to your appointment date. If you send payment by check, we will hold your check (it will not be deposited) or if paying by credit card, we will not run your credit card payment until 2 weeks prior to your appointment.

We accept cash, checks, Visa, MasterCard or debit card.

Please make your checks payable to the: HASPC of Central Ohio

Please mail your checks to: The HASPC of Central Ohio
350 W Wilson Bridge Rd, Suite 320
Worthington, OH 43085

NOTE: If you choose to use a credit or debit card for payment, please call the office with the card number, expiration date and code on the back of the card.

If you have any questions regarding billing or payments, please contact us at (614) 396-8703 or info@HASPCofCentralOhio.com

Name____
Please Print

Signature______________________________________

Date____________________

Authorization Release for Medical Information

Patient's Name: ______________________ ______________________ __________
Last First Middle Initial

DOB: ____________________

Address: ____

City/State/Zip: ____

Home/Cell Number: ____

I hereby authorize (Doctor's Name): ____

Address: ____

City/State/Zip: ____

Phone Number: ______________________ Fax Number: ______________________

To release my medical records to:
Eric A. Goulder, MD, FACC
350 W Wilson Bridge Rd, Suite 320 Worthington, OH 43085
Phone: (614) 396-8703 Fax: (614) 614-885-6085

Please send the following information:

- Most recent complete physical exam
- Laboratory tests (last 2 yrs)
- Most recent EKG
- Stress test, any cardiovascular test (echo, calcium score and etc…..)
- Chest X-ray
- Consultation reports from specialists concerning: diabetes or cardiovascular disease (last 2 yrs)
- Medication list

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus) and other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I hereby release (Medical Provider's Name)______________________________and staff from all legal responsibility that may arise from the act herby authorized.

Patient's Signature:______________________________Date: ______________

Guardian/Legal Representative:______________________________Date: ______________

To be valid, this authorization must be dated within 90 days of the request for the information and can be revoked at any time, if the information has not yet been released. No information for medical treatment received after the date of this authorization will be released.

The Heart Attack & Stroke Prevention Center of Central Ohio
A partnership in medicine and dentistry

Bale Doneen METHOD

Authorization Release of Dental Records

Patient's name: L_________________________ F____________________________ MI__________

DOB:____

Address:____

City/State/Zip ____

Home/Cell Phone:____

I hereby authorize (dentist's name) ____

Address:____

City/State/Zip____

Office number:_______________________ Fax number: __________________________________

To release my dental records to:

Eric A. Goulder, MD, FACC

350 Wilson Bridge Road, Worthington, Ohio 43085

Phone: (614) 396-8703 Fax: (614) 885-3333

Please send the following dental records:

- Comprehensive exam date, notes and recare interval
- Cone beam scan or pan x-ray
- Full periodontal chart and history of treatment
- Oral DNA or saliva test dates and results
- Sleep screening reports
- History of oral cancer screenings and findings

Patient's signature:____Date:__________

Guardian/Legal representative:____Date:__________

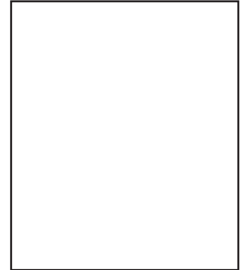
To be valid, this authorization must be dated within 90 days of the request for the information and can be revoked at any time, if the information has not been released. No additional information for medical treatment will be released, if provided after the date of this authorization.

The Heart Attack & Stroke
Prevention Center of Central Ohio

A partnership in medicine and dentistry

350 W Wilson Bridge Rd, Suite 320
Worthington, OH 43085
Phone: (614) 396-8703 Fax: (614) 614-885-6085

2017 Demographics



Date ______________________ Male ☐ Female ☐

Name ______________________ ______________________ ______________________
First *Middle* *Last*

Date of Birth ______________________ Social Security Number ______________________

Home Phone ______________________ Work Phone ______________________

Cell Phone ______________________ Email ______________________

Mailing Address ______________________ City ______________________

State __________ Zip ______________

Marital Status S ☐ M ☐ D ☐ W ☐

Physical/Secondary Address ______________________ City ______________________

State __________ Zip ______________ Date From ______________ to ______________

Spouse/Emergency Contact ______________________

Phone Number ______________________ Relationship ______________________

Primary Insurance Company ______________________

ID Number ______________________ Group Number ______________________

Secondary Insurance Company ______________________

ID Number ______________________ Group Number ______________________

Person Responsible for Bill ______________________

____
Patient's Signature

Reviewed: Initial/Date

The Heart Attack & Stroke
Prevention Center of Central Ohio

A partnership in medicine and dentistry

Bale Doneen METHOD

Health History

Name:______________________________ Date:______________ Date of birth: ______________

How did you find out about the practice?____

Your answers will give us a better understanding of your medical concerns and conditions. If you are uncomfortable with any questions, feel free not to answer them. Best estimates are fine; however, be specific whenever you can. Please contact family members if you need assistance completing the family history section. If you need more space, simply attach as many additional pages as you need. ***Thank you!***

How would you rate your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current age:__________ Weight:__________ Height:__________ Ethnicity: ______________

Waist measurement:__________ Date of your last physical exam:______________

Medications: Please list all prescription and non-prescription medications, vitamins, home remedies, and herbs.

Medication/Supplements	*Dose (mg per pill, doses per day)*	*Start date*	*Reason*

Blood type ________________

Allergies or reactions to medicines: ____

When was your most recent:

- Cholesterol screening ______________
- Chest X-ray ______________
- Lung function ______________
- Colonoscopy ______________
- Endoscopy (upper GI) ______________
- Peripheral Vascular Disease test (ABI) ______________
- EKG ______________
- IMT ______________
- Bone density test ______________
- Flu vaccine ______________
- Shingles vaccine ______________
- Pneumovax ______________
- Dental exam ______________
- Eye exam ______________
- Coronary CT Scan ______________

Any other vascular test (Please specify) ____

Bale Doneen METHOD

Name: ______________________________

Health History

Personal medical history

Please indicate whether you have had any of the following medical problems
(Include dates to indicate when the problem occurred.)

- Heart Disease ☐ ________
- Stroke ☐ ________
- High Cholesterol ☐ ________
- High blood Pressure ☐ ________
- Pre-diabetes ☐ ________
- Diabetes ☐ ________
- Mini-Stroke or TIA ☐ ________
- Atrial Fibrillation ☐ ________
- Poor blood flow to extremities ☐ ________
- Poor blood flow to intestines ☐ ________
- Poor blood flow to kidneys ☐ ________
- Aortic Aneurysm ☐ ________
- Brain Aneurysm ☐ ________
- Bleeding/clotting problems ☐ ________
- Blood transfusions ☐ ________
- Anemia ☐ ________
- High red blood cell count ☐ ________
- Leukemia ☐ ________
- Abnormal platelet count ☐ ________
- Heart Arrhythmia ☐ ________
- Heart Valve Problem ☐ ________
- Rheumatoid Arthritis ☐ ________
- Kidney Disease ☐ ________
- Kidney stones ☐ ________
- Gallbladder stones ☐ ________
- Pancreatic disease ☐ ________
- Fatty liver ☐ ________
- Lupus ☐ ________
- Psoriasis ☐ ________
- Sjögren’s Syndrome ☐ ________
- Autoimmune disorder ☐ ________
- Periodontal Disease ☐ ________
- Dental infections ☐ ________
- Root Canal ☐ ________
- Bleeding gums ☐ ________
- Gout ☐ ________
- Polycystic Ovaries ☐ ________
- Thyroid problems ☐ ________
- Depression ☐ ________
- Suicide attempts ☐ ________
- Anxiety/Panic Attacks ☐ ________
- Migraine Headaches ☐ ________
- Thin Bones/osteoporosis ☐ ________
- Stomach Ulcers ☐ ________
- Chronic Heartburn ☐ ________
- Restless legs ☐ ________
- Sleep disorder ☐ ________
- Hormone imbalance ☐ ________
- Toxin Exposure ☐ ________
- Unexplained Nerve Problems ☐ ________
- Cancer ☐ ________
- Physical disability ☐ ________
- Mental disability 1 ☐ ________
- Mental disability 2 ☐ ________
- Post-traumatic stress syndrome ☐ ________
- Celiac Disease ☐ ________
- Diverticulosis ☐ ________
- Irritable Bowel Syndrome ☐ ________
- Gluten Intolerance ☐ ________
- Blood clot in legs ☐ ________
- Hodgkin’s Disease ☐ ________
- History Hepatitis ☐ ________
- Alcoholism ☐ ________
- Drug use ☐ ________
- History AIDS ☐ ________

The Heart Attack & Stroke
Prevention Center of Central Ohio

A partnership in medicine and dentistry

Bale Doneen METHOD

Name: ____

Health History

Have you ever been hospitalized for illness? ☐ Yes ☐ No

If so, when and why:
____
____
____

Surgical history

Please list all other operations with the dates when they occurred.
____
____
____
____
____
____

Social history

Tobacco use

Cigarettes: ☐Never ☐Quit: date you quit smoking ______________ ☐ Current smoker: (packs per day)________

Other tobacco (check all answers that apply): ☐ Pipe ☐ Cigar ☐ Chewing tobacco ☐E-cigarettes ☐Marijuana

Number of years you've used this tobacco _____________

Are you interested in quitting? ☐Yes ☐No Have you tried to quit in the past? ☐ Yes ☐No

How many times have you tried to quit?______What methods have you tried?___________________________________

Are you exposed to second hand smoke? ☐ Yes ☐ No If yes, for how long? ____________________

Alcohol use

Do you drink alcohol? ☐Yes ☐No

If yes, how many drinks do you consume per week?_____________Alcohol type ________________________________

Does your alcohol consumption have you or others concerned? ☐ Yes ☐ No

Other concerns

Caffeine intake

Coffee______cups/day Tea______cups/day Sodas per day______ ☐ Diet ☐ Regular

Chocolate______ounces per day (Check one.) ☐Dark ☐Light

Do you drink energy drinks or take pills to stay awake? ☐ Yes ☐ No If yes, specify____________________________

Decaffeinated products? ☐Yes ☐No If yes, specify / how much____

Weight

Are you satisfied with your weight? ☐Yes ☐No What is your goal weight?______________

When did you last weigh your goal weight?___________How long were you at that weight? _______________

Name: ______________________________

Health History

Exercise

Do you exercise regularly? Yes No

What kind of exercise? ______________________________

How long do you exercise in minutes? __________ How often? ______________________________

If you do not exercise, why not? ______________________________

Do you have any limitations to your ability to exercise? Please explain: ______________________________

Socioeconomics

Occupation ______________________________

Employer ______________________________

Years of education/highest degree __________

Marital status: Single Married Divorced Widowed

Spouse/partner's name ______________________________

Who lives at home with you? ______________________________

How many children do you have? (Please provide names, gender, and ages.) ______________________________

____

Where were you born? ______________________________ Where did you grow up? ______________________________

Where do you live now and for how long? ______________________________

Oral Health:

How many times per day do you brush your teeth? _______ What type of toothbrush do you use? ______________________________

Do you floss regularly? Yes No How often? __________

How often do you see your dentist? __________ Do you ever have bleeding gums? Yes No

Does your oral health concern you? Yes No If yes, why? ______________________________

Stress

How would you classify your stress level at work? (Please check one) ☐ Low ☐ Medium ☐ High

How would you classify your stress level at home? ☐ Low ☐ Medium ☐ High

Do you often feel anxious, angry, irritated or rushed? Yes No

How do you manage your stress? ______________________________

List ways for which you relax? ______________________________

Do you meditate daily? Yes No If yes, how? ______________________________

Do you perceive a lack of control of your environment? Yes No If yes, why? ______________________________

Diet

How do you rate your diet? (Please check one) ☐ Good ☐ Fair ☐ Poor

Do you currently see a dietitian? Yes No If yes, how often? _________ Name and contact:

How many daily servings of the following do you have:

Whole grains	_________	Nuts	_________
Water	_________	Vegetables	_________
Fruit	_________	Milk	_________ what % _________

How many times a week do you consume the following items?

Eggs	_________	Margarine	_________
Fish	_________	Dairy Products	_________
Chicken/Turkey	_________	Fried Foods	_________
Red Meat	_________	Processed foods	_________
Butter	_________	Going out to eat	_________

Do you have any food allergies or food sensitivities? Yes No

If yes, please explain: ______________________________

Please List ALL supplements: ______________________________

Bale Doneen METHOD

Name: ____

Health History

History for Men:

Do you have problems with erections? Yes No If yes, date of onset___________________

Do you have problems with sexual desire or sex drive? Yes No If yes, date of onset___________________

Do you have problems with sexual satisfaction? Yes No If yes, date of onset___________________

Do you have problems with decreased energy or decreased muscle strength? Yes No If yes, date of onset___________________

History for Women:

How many times have you been pregnant?________How many deliveries?________miscarriages? ________

Please list any problems you have experienced with pregnancy or delivery: ____________________________________

Do you have osteoporosis (bone loss)? Yes No Osteopenia (bone thinning)? Yes No

When was the first day of your most recent period?__________ What was your age at your first period? __________

Frequency of periods_________ Length of each_________ (Check one) ☐ Regular ☐ Irregular

Menopause? Yes No

Hysterectomy? Yes No When_________Ovaries removed? Yes No

Do you have any history of gestational diabetes? Yes No

High blood pressure or eclampsia with pregnancy? Yes No

Did any of your children weigh more than eight pounds at birth? Yes No

Do you have problems with sex drive? Yes No If yes, date of onset___________________

Do you have problems with sexual satisfaction? Yes No If yes, date of onset___________________

Bale Doneen METHOD

Name: ______________________________________

Health History

Travel History:

Any recent international travel? Yes No

If yes, What Countries and dates of stay ______________________________

Any illnesses during or post travel? ______________________________

Review of symptoms

Please check any current problems you have on the list below.

Constitutional:
- Fever/chills/sweats
- Unexplained weight loss/gain
- Brittle nails
- Dry skin
- Change in skin texture
- Change in hair texture
- Inability to stand heat
- Inability to stand cold
- Change in energy/increased weakness
- Excessive thirst or urination
- Swelling (Explain)______________________

Respiratory:
- Cough/wheeze
- Difficulty breathing
- Snoring
- Sleep apnea/CPAP Frequent respiratory infections

Eyes:
- Change in vision (Explain)__________________
- Dry Eyes
- Frequent irritation
- History of retinal tear or hemorrhages
- Double vision
- Glaucoma (Treatment?)__________________
- Cataracts (Surgery?)__________________

Ear/Nose/Throat/Mouth:
- Difficulty hearing/ringing in your ears
- Hay fever/allergies
- Bleeding gums
- Dental Cavities
- Painful teeth or gums
- Bad breath
- Root canals
- Dental implants

Cardiovascular:
- Chest pain/discomfort
- Palpitations (irregular heart beats)
- Swelling in feet or legs
- Varicose veins
- Pain in extremities with exercise

Skin:
- Acanthosis nigricans (dark lines around neck or under arms)
- Skin tags
- Flattening of nail beds
- Creases in earlobes
- Frequent itching of skin
- Skin infections

Genitourinary:
- Unusual frequency of urination
- Increased urination at night that interrupts sleep
- Blood in urine

Gastrointestinal:
- Abdominal pain
- Blood in bowel movement
- Heartburn
- Nausea/vomiting
- Diarrhea/constipation
- Loss of appetite
- Weight loss
- Weight gain

Neurological:
- Headaches
- Light-headedness
- Memory loss
- Loss of coordination
- Tingling, pain, or numbness in hands or feet

Psychiatric:
- Problems with sleep
- Depression
- Panic attacks
- Mania
- Anxiety
- Anger issues
- Short temper or impatience
- Unusual feeling of doom
- Suicidal thoughts
- Hopelessness and constant worry

Blood/Lymphatic:
- Easy bruising/bleeding
- Unexplained lumps
- Unusual bleeding
- Unusually pale
- Unusual rudy appearance
- History of blood clots
- History of low platelet counts
- History of high platelet counts
- History of low white blood cell counts
- History of anemia

Muscle/Skeletal:
- Chronic joint problem
- Back problems
- Neck problems
- Spine problems
- Muscle injuries
- Arthritis
- History of bone fractures
- History of torn or ruptured tendons
- Paralysis of any muscles
- Unusual muscle weakness
- Any muscle side effects from statins

Any other symptoms? If so, please list them: ____________________

____

Name: ______________________________

Health History

Family history

Please indicate the current status of your immediate family members. Include if each person is alive or deceased; the person's age now or at time of death; if applicable, the cause of death; and any other relevant comments.

Mother's mother ______________________________

Mother's father ______________________________

Father's mother ______________________________

Father's father ______________________________

Mother ______________________________

Father ______________________________

Sister ______________________________

Sister ______________________________

Sister ______________________________

Brother ______________________________

Brother ______________________________

Brother ______________________________

Daughter ______________________________

Daughter ______________________________

Daughter ______________________________

Son ______________________________

Son ______________________________

Son ______________________________

Please use this space to list any additional family members:

____

____

____

____

The Heart Attack & Stroke Prevention Center of Central Ohio

A partnership in medicine and dentistry

Bale Doneen METHOD

Name: ___________________________________

Health History

Please indicate any family members who have had any of the following medical conditions:

Medical condition	Mom	Dad	Sister	Brother	Daughter	Son	Mom's mom	Mom's dad	Dad's mom	Dad's Dad	Mom's sister	Mom's brother	Dad's sister	Dad's brother
Heart attack														
Stroke														
Diabetes-Type 2 (adult onset)														
Alcoholism														
Anemia														
Aortic aneurysm														
Alzheimer's														
Arthritis														
Asthma														
Autoimmune disorder														
Bleeding problems														
Carotid artery disease														
Cancer														
Depression														
Diabetes-Type 1 (childhood onset)														
Other genetic disease														
High cholesterol (hyperlipidemia)														
High blood pressure (hypertension)														
Immunosuppressive disorders														
Kidney disease														
Osteoporosis														
Peripheral vascular disease														
Epilepsy (seizure disorder)														
Substance abuse														
Thyroid disorder														
Smoking														
Sleep apnea														
Polycystic ovary Disease														
Coronary bypass														
Coronary stents														
Mini strokes														
Gum Disease														
Bad teeth														

Bale Doneen METHOD

Physician/Provider Information Form

Patient's Name: ____________________ ____________________ __________
Last First Middle Initial

Your primary care provider: ____________________

Specialty: ____________________

Last visit: ____________________ Frequency of visits: ____________________

Telephone: ____________________ Fax: ____________________

Address: ____________________

Dental provider: ____________________

Specialty: ____________________

Last visit: ____________________ Frequency of visits: ____________________

Telephone: ____________________ Fax: ____________________

Address: ____________________

Other attending provider: ____________________

Specialty: ____________________

Last visit: ____________________ Frequency of visits: ____________________

Telephone: ____________________ Fax: ____________________

Address: ____________________

Other attending provider: ____________________

Specialty: ____________________

Last visit: ____________________ Frequency of visits: ____________________

Telephone: ____________________ Fax: ____________________

Address: ____________________

Other attending provider: ____________________

Specialty: ____________________

Last visit: ____________________ Frequency of visits: ____________________

Telephone: ____________________ Fax: ____________________

Address: ____________________

Bale Doneen METHOD

Notice of Privacy Practices

January 1, 2017

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal medical provider or others working this office. This notice will inform you about the ways we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations

We are required by law to:

Make sure that health information that identifies you is kept private.
Give you this notice of our legal duties and privacy practices with respect to health information.
Follow the terms of the Notice of Privacy Practices that is currently in effect.

How we may use and disclose health information about you:

For treatment, for payment, for health care operations, for appointment reminders, as required by law, public health risks, health oversight activities, lawsuits and disputes, law enforcement, coroners, health examiners and funeral directors, to avert a serious threat to health and safety, as required by the military or veterans administration, national security, inmates, workers' compensation.

Your rights regarding health information about you:

Right to inspect and copy, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice.

Changes to Notice of Privacy Practices:

We reserve the right to change this notice. We will post a copy of the current notice in our facility with the current effective date.

Complaints:

If you believe that your privacy rights have been violated you may file a complaint with us. All complaints must be in writing.

Acknowledgment of Receipt of this Notice:

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgment will become part of your records.

Patient Signature____Date____________________________

Bale Doneen METHOD

Patient Records of Disclosures

Acknowledgement of Review of Notice of Privacy Practices

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner.
(Please √ in each section)

Patient's Name: ______________________ ______________________ ________
Last First Middle Initial

☐ Home Telephone: ______________________
- ☐ Leave message with detailed information
- ☐ Leave message with a call back number
- ☐ Do not leave a message

☐ Work Telephone: ______________________
- ☐ Leave message with detailed information
- ☐ Leave message with a call back number
- ☐ Do not leave a message

☐ Cell Telephone: ______________________
- ☐ Leave message with detailed information
- ☐ Leave message with a call back number
- ☐ Do not leave a message

☐ Fax Number: ______________________
- ☐ Please do not fax any information to me

☐ Email: ________________________________
- ☐ Please do not email any information

☐ Written Communication:
- ☐ Mail to my home
- ☐ Mail to my work/office
- ☐ Do not mail

The following people may have access to my medical information:
- ☐ Spouse: ____________________
- ☐ Child: ____________________
- ☐ Child: ____________________
- ☐ Child: ____________________
- ☐ Child: ____________________
- ☐ Other: ____________________
- ☐ Nobody

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

____ ______________________
Signature of Patient or Personal Representative Date