

# VASCULAR SURGICAL ASSOCIATES, P.C.

(Please Print)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Chart No.: \_\_\_\_\_ Employee Init.: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell/Pager: ( ) \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: M F

Home Email Address: \_\_\_\_\_

Social Security No: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: Married Single Divorced Widowed

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Spouse: \_\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: ( ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Are you a dialysis patient? Yes \_\_\_\_ No \_\_\_\_ If so, please list your doctor: \_\_\_\_\_

Dialysis Center: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Traditionally, we have mailed reminders to patients who need to schedule appointments for periodic follow-up. We now offer alternative means of reminding you to schedule an appointment. Please specify your preference. Mail \_\_\_\_ Patient Portal (Web site) \_\_\_\_ Telephone \_\_\_\_

## INSURANCE INFORMATION (If you have insurance, please answer the questions below.)

Do you have a Health Savings or Reimbursement Account? Yes No

Name of Primary Insurance Company: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Member Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Does this insurance company require a referral from a primary care physician? Yes No Copay? \$ \_\_\_\_\_

If Yes, was this obtained? Yes No

Name of Secondary Insurance Company: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Member Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Does this insurance company require a referral from a primary care physician? Yes No Copay? \$ \_\_\_\_\_

If yes, was this obtained? Yes No

**AUTHORIZATION, RELEASE, AND FINANCIAL RESPONSIBILITY:** I hereby authorize Vascular Surgical Associates P.C. or its representatives to release any information acquired in the course of my examination or treatment to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, workers' compensation carriers, adjusters or attorneys. I instruct and direct my insurance carrier(s) to pay Vascular Surgical Associates, PC by check or electronic remittance for services billed to them on my behalf. I agree to pay any portion determined my responsibility by my insurance carrier including but not limited to co-payments, deductibles, and non-covered services. I assume full financial responsibility for services not covered by insurance.

I authorize representatives of Vascular Surgical Associates to discuss or otherwise share information regarding my condition and treatment with the individuals listed below. This authorization may be revoked at any time.

Name	Relationship	Name	Relationship
1) _____	_____	3) _____	_____
2) _____	_____	4) _____	_____

A photocopy of this document shall be considered as valid as the original. The undersigned certifies that he/she understands and agrees to the terms outlined above.

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



Vascular Surgical Associates, PC  
Patient Acknowledgment Form

Patient Acknowledgment of Receipt of Vascular Surgical Associates' Privacy Practices

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Previous name: \_\_\_\_\_

I understand that the patient's health information is private and confidential. I understand that Vascular Surgical Associates personnel work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Vascular Surgical Associates may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Vascular Surgical Associates has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Vascular Surgical Associates may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Vascular Surgical Associates will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Vascular Surgical Associates has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Vascular Surgical Associates by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Vascular Surgical Associates' "Notice of Privacy Practices".

\_\_\_\_\_  
Signature Date Time

\_\_\_\_\_  
Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Would you like us to discuss your private health information with any other individual (e.g. spouse, child)? yes no

# VASCULAR SURGICAL ASSOCIATES, P.C.

## PATIENT MEDICAL HISTORY INFORMATION

NOTE: There are two sides to this form. Please be as complete and specific as possible.

Name:	Age:	Weight:	Marital Status: S M W D
Date:	D.O.B.	Ref. Dr.	

<b>Do you have, or have you ever had:</b>			
High blood pressure	<input type="radio"/> Yes	<input type="radio"/> No	Stroke
Congestive heart failure	<input type="radio"/> Yes	<input type="radio"/> No	Asthma
Heart attack	<input type="radio"/> Yes	<input type="radio"/> No	Arthritis
Thyroid disease	<input type="radio"/> Yes	<input type="radio"/> No	Phlebitis
Kidney disease	<input type="radio"/> Yes	<input type="radio"/> No	Cancer (type)_____
Tuberculosis	<input type="radio"/> Yes	<input type="radio"/> No	Varicose veins
Pulmonary embolus	<input type="radio"/> Yes	<input type="radio"/> No	Blood clots
Diabetes	<input type="radio"/> Yes	<input type="radio"/> No	Bleeding
Other_____			Other_____

Reason for today's visit: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List current medications (name & dose): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any medications you are allergic to:  None \_\_\_\_\_

List any surgeries you have had and the dates:  None

Procedure	Date	Procedure	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any problems with surgery or anesthesia: \_\_\_\_\_

Do you smoke?  Yes  No How much and how long? \_\_\_\_\_ Drink?  Yes  No How much? \_\_\_\_\_

Recreational Drugs?  Yes  No What? \_\_\_\_\_

Occupation: \_\_\_\_\_

Has anyone in your family ever had any of the following conditions?

	Indicate Relationship						
				Maternal		Paternal	
	Mother	Father	Brother	Sister	Grmother/Grfather	Grmother/Grfather	Grmother/Grfather
Cancer	<input type="radio"/> Yes	<input type="radio"/> No	_____	_____	_____	_____	_____
Diabetes	<input type="radio"/> Yes	<input type="radio"/> No	_____	_____	_____	_____	_____
High blood pressure	<input type="radio"/> Yes	<input type="radio"/> No	_____	_____	_____	_____	_____
Aneurysm	<input type="radio"/> Yes	<input type="radio"/> No	_____	_____	_____	_____	_____
Stroke	<input type="radio"/> Yes	<input type="radio"/> No	_____	_____	_____	_____	_____
Clotting problems	<input type="radio"/> Yes	<input type="radio"/> No	_____	_____	_____	_____	_____
Heart Disease	<input type="radio"/> Yes	<input type="radio"/> No	_____	_____	_____	_____	_____

**Have you had any of the following in the last 12 months?**

**General**

- Fever .....  Yes  No
- Weight loss/changes .....  Yes  No
- Chills.....  Yes  No
- Fatigue.....  Yes  No

**ENT**

- Hearing loss .....  Yes  No
- Mouth sores .....  Yes  No
- Swallowing difficulties.....  Yes  No

**Cardiac**

- Chest pain.....  Yes  No
- High blood pressure .....  Yes  No
- Palpitations .....  Yes  No
- Swelling of arms or legs .....  Yes  No

**Respiratory**

- Chronic cough.....  Yes  No
- Shortness of breath.....  Yes  No
- Coughing up blood .....  Yes  No

**Vascular**

- Varicose veins.....  Yes  No
- Pain in feet at rest .....  Yes  No
- Pain in legs with walking.....  Yes  No
- Vascular testing.....  Yes  No

**Gastrointestinal**

- Abdominal pain .....  Yes  No
- Nausea/vomiting .....  Yes  No
- Constipation/diarrhea .....  Yes  No
- Appetite changes .....  Yes  No

**Endocrine**

- Heat or cold intolerance.....  Yes  No
- Excessive thirst .....  Yes  No
- Tired/sluggish.....  Yes  No

**Genitourinary**

- Blood in urine .....  Yes  No
- Frequent/Painful urination.....  Yes  No
- Erectile Dysfunction.....  Yes  No
- Number of pregnancies ..... \_\_\_\_\_

**Musculoskeletal**

- Joint pain.....  Yes  No
- Back pain .....  Yes  No
- Muscle cramps/pain.....  Yes  No
- Past injuries .....  Yes  No

**Skin/Integumentary**

- Rash .....  Yes  No
- Sores .....  Yes  No
- Discoloration .....  Yes  No
- Healing problems .....  Yes  No

**Neurological**

- Headaches.....  Yes  No
- Loss of vision .....  Yes  No
- Clumsiness .....  Yes  No
- Arm/leg weakness .....  Yes  No
- Seizures.....  Yes  No
- Burning of toes, feet, hands.....  Yes  No
- Numbness/tingling.....  Yes  No
- Difficulty speaking .....  Yes  No

**Psychiatric**

- Depression.....  Yes  No
- Nervousness .....  Yes  No
- Insomnia .....  Yes  No

**Hematological/Lymphatic**

- Swollen glands .....  Yes  No
- Phlebitis .....  Yes  No
- Blood clotting problems .....  Yes  No

**FOR OFFICE USE ONLY.**

Date form reviewed \_\_\_\_\_  
 Initials of reviewer \_\_\_\_\_

\_\_\_\_\_  
 Patient Signature Date  
 Print Name \_\_\_\_\_