VASCULAR SURGERY ASSOCIATES

New Patient Registration

Staff Use Only: PID#:_____ Scanned by (Initials): _____

Patient Arrival Time: _____ AM / PM

PLEASE FILLOUT ALL FORMS COMPLETELY

Patient Information: *Need help with Forms?* ☐ *Y* ☐ *N* | Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Name: (LAST) _____ (FIRST)_____ (MI)_____ (Suffix) _____

Minor☐ Y ☐ N Date of Birth: _____ /_____/ _____ Social Security (Optional):_____-_____-_____ Sex: ☐ M ☐ F

Street Address: _____ (Apt #) _____ (City) _____

(State)_____ (Zip) _____ (Country) _____ Home Phone: _____ Cell Phone: _____

Best Form of Contact: ☐ Home Phone ☐ Cell Phone | Best Time: _____|May *we leave a detailed voice message?* ☐ *Y* ☐ *N*

Email: _____ Martial status __M__S__D__W__Other

Primary Care Physician: (Name)_____ (Phone)_____ (City) _____

Preferred Pharmacy: (Name) _____ (Location) _____ (Phone) _____

Emergency Contact: (Name) _____ (Phone) _____(Relationship)_____

Guarantor: Is your address the same as the Patient/Minor's address? ☐ Yes ☐ No | ***If no***, provide information below.

Name of Guarantor: _____ Guarantor Date of Birth: _____ / _____ / _____

Street Address: _____ (Apt #) _____ (City) _____

(State)_____ (Zip) _____ (Country) _____ Home Phone: _____ Cell Phone: _____

Patient Authorization to Release Medical Records (To a Doctor or Family Member)

☐ **Patient Authorization to Release Medical Records:** I authorize the custodian of records or other person/entity (specifically describe) to disclose/release the following information* (check all applicable): ☐ All Records ☐ Billing Records ☐ Other _____

Note If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or STDs, you are hereby authorizing disclosure of this information. **To (Name):** _____ **Relationship:** _____

Signature of Patient (or Guardian):_____ Date: _____ / _____ / _____

☐ **Insured** –Primary Ins Subscriber Name: _____ Secondary Ins Subscriber Name:_____

Name of Primary Ins: _____ Name of Secondary Ins: _____

Primary Subscriber Number: _____ Date of Birth: (*if not patient*) _____ Relationship: _____

Secondary Subscriber Number: _____ Date of Birth: (*if not patient*) _____ Relationship: _____

☐ **Auto** – Name of Ins: _____ Phone: _____ Accident/Claim #:_____

☐ **Work Related** - Company Name: _____ DER (Company Representative): _____

Company Phone Number: _____ Email: _____

☐ **Self-Pay** (FFS)

Race:

__ American Indian or Alaska ___Native Asian

___Black or African American ___Native Hawaiian or Other Pacific Islander

___White ___Other

___Declined

Ethnicity:

____Hispanic or Latino

____Not Hispanic or Latino

VASCULAR SURGERY ASSOCIATES
Patient Acknowledgement & Consent
Treatment Coverage & Communication

Please ***initial and sign*** to **select** your current **method of coverage**, and to complete the acknowledgement and consent for Medical Treatment, Notice of Privacy Practices, and Payment Policy.

___Self-Pay (FFS) Patient Visit

By signing below, I acknowledge that I have been informed of my responsibility to pay for the professional services or supplies provided to me today by Vascular Surgery Associates.
I understand that these costs must be paid prior to the provision of such services through its authorized representatives.
I acknowledge and fully understand that the service(s) requested today will not be billed to any insurance carrier(s) at my request. I also understand that today's service(s) will be provided at a discounted rate and waive any right that I may have to require Vascular Surgery Associates to attempt to bill any insurance carrier for these services. I further acknowledge that if I choose to submit an itemized receipt to any insurance carrier(s) for evaluation of partial or full reimbursement for these services that Vascular Surgery Associates is exempt from any subsequent dispute regarding reimbursement but retains the option to submit these services for payment under the non-discounted insurance rates and guidelines upon mutual agreement by both parties when appropriate insurance information has been provided to Vascular Surgery Associates.

___Health Insured Patient Visit

I request that payment of authorized insurance benefits, including Medicare, be made on my behalf for any professional services or supplies provided to me by Vascular Surgery Associates.
I acknowledge that I have provided my insurance information today and authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related professional services or supplies by Vascular Surgery Associates to the Health Care Financing Administration, my insurance company or other entity upon request to secure payment of my benefits.
I understand that I am financially responsible to Vascular Surgery Associates for any charges not covered by health care benefits. It is my responsibility to notify Vascular Surgery Associates of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that I am responsible for the entire bill including any unpaid balance of the professional services or supplies as determined by Vascular Surgery Associates and/or my health care insurer should the submitted claim or any part of the claim be denied for payment or apply to my co-pay, deductible or coverage limitations.

___CONSENT TO MEDICAL TREATMENT

I voluntarily present for treatment and consent to my Vascular Surgery Associates provider to provide my care. Such care may include, but is not limited to, diagnostic procedures, x-rays, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care.
I acknowledge that my treatment is intended to address specific, episodic illnesses or injuries and is not intended as a substitute for a primary care physician or other specialized physician and that no guarantee can be made or has been made as to the results of treatments or examinations at Vascular Surgery Associates.

___NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge review of Vascular Surgery Associates Notice of Privacy Practices, with a copy available upon request, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

___OFFICE POLICY ON PAYMENT

It is our policy to require all co-payments to be made at the time of service. The undersigned agrees to pay all costs charged by the Collection Company and reasonable attorney fee.
I understand that by signing this form I am accepting full financial responsibility as explained above for all professional services and supplies received. I understand this original authorization will be kept on file by Vascular Surgery Associates and does not expire unless written notice is provided by me.

Name of person signing below (print):

_____

Signature of Patient or Guardian:

_____

Today's (Visit) Date:

_____

Relationship to Insured:
☐Self ☐Spouse ☐Dependent ☐Other

Relationship to Patient:
☐Self ☐Spouse ☐Guardian ☐Other

Please tell us what you would like to be seen for today:

_____

When did it start bothering you? _____ (date of onset)

Were you injured? ❍No ❍Yes ⇨ ❍At work ❍Auto accident ❍At home ❍Other_____

Next, review the symptoms below and mark the circle(s) next to any symptoms **related to your visit today**.

If an area is normal, or not related to today's visit, do not mark that circle.

VASCULAR SURGERY ASSOCIATES

GENERAL
- ❍ Pain _____ (location)
- ❍ Fever ❍ Chills
- ❍ Fatigue
- ❍ Weakness
- ❍ Unusual weight changes

EYES
- ❍ Something in eye
- ❍ **Vision problem** (blurry, loss of sight)
- ❍ Dryness ❍ Scratchy sensation
- ❍ Redness
- ❍ Excessive tearing
- ❍ Wear glasses / contacts

EARS
- ❍ Ringing in ears
- ❍ Hearing loss

NOSE
- ❍ Nosebleed
- ❍ Sinus Pain
- ❍ Runny nose

MOUTH, THROAT
- ❍ Growth in mouth ❍ White spots
- ❍ Tongue pain
- ❍ Toothache
- ❍ Soreness ❍ Trouble swallowing
- ❍ Swelling
- ❍ Hoarseness

HEART & CIRCULATION
- ❍ **Chest pain** ❍ Tightness ❍ Pressure
- ❍ Faintness ❍ Lightheaded
- ❍ Fast heartbeat ❍ Slow heartbeat ❍ Palpitations

LUNGS
- ❍ **Shortness of breath**
- ❍ Cough ❍ Wheezing
- ❍ Snoring ❍ Apnea

STOMACH, INTESTINES
- ❍ Nausea ❍ Vomiting ❍ **Rectal Bleeding**
- ❍ Indigestion ❍ Food intolerance ❍ Cramping
- ❍ Diarrhea ❍ Constipation ❍ Bloating ❍ Gas

***Clinic Use Only**: Provider Name:* _____

***Clinic Use Only**: Provider Signature:* _____

***Clinic Use Only:** Date:* _____

GENITAL
❍ Sores ❍ Discharge ❍ Bleeding ❍ Pain
❍ Swelling ❍ Abnormal Period Last Period: _____

URINARY
- ❍ Frequent urinating ❍ Painful urinating
- ❍ Losing control of urine/wetting self
- ❍ Blood in urine (discolored urine)

MUSCLES, JOINTS & BONES
- ❍ Joint stiffness ❍ Pain _____(location)
- ❍ Muscle pain ❍ Cramps _____(location)

SKIN
- ❍ **Wound**/Sore _____ (location)
- ❍ Rash _____(location)
- ❍ Dryness ❍ Itchiness

BLOOD/LYMPH
- ❍ Easy bruising ❍ Easy bleeding

ALLERGIES
- ❍ Seasonal Allergies ❍ Hives ❍ Welts
- ❍ **Other**: _____

NERVOUS SYSTEM
- ❍ **Recent head injury** ❍ Dizziness/Vertigo
- ❍ Speech problems ❍ Memory loss
- ❍ Fainting ❍ **Blacking out**
- ❍ **Seizures** ❍ **Sudden Paralysis**
- ❍ Headaches
- ❍ Poor balance ❍ Loss of coordination
- ❍ **Tingling** ❍ Numbness ❍ Weakness

PSYCHOLOGICAL
- ❍ Depression ❍ Loss of interest
- ❍ Nervousness ❍ Anxiety

HORMONES
- ❍ Heat intolerance ❍ Cold intolerance
- ❍ Night sweats
- ❍ Increased thirst ❍ Hunger

Patient Name: _____

Patient Signature: _____

Patient Date of Birth: _____

Primary Care Provider: _____

Today's Date: _____ (date of visit)

Adult History and Review of Systems Questionnaire

Note: This is a confidential record of your medical history. As your doctors, it is important for us to know this information so we can provide you with the best health care possible. The information contained here will not be released to anyone without your prior consent.

Name _____ Date _____

Date of Birth _____ □ Male □ Female Spouse\Significant Other _____

SOCIAL HISTORY:

Birthplace _____ Your Occupation _____

Nationality _____ Education _____

Drug Use_____ Marital Status _____How many years_____

Tobacco Use □ Yes □ No Type _____ Children_____

Packs per day ____ for _____ years Quit _____

Alcohol Use _____

Drinks _____ per □ day □ week □ month Pets _____

Exercise (type/how often?)_____

If heavy use, how many years _____ Quit _____ Recent or Frequent Travel Destinations _____

Caffeine (coffee, tea, soda, chocolate) Servings per day_____

Have YOU ever had? (IF YES, CHECK APPROPRIATE BOXES)

□ Cancer Type:_____
□ Heart Attack/Coronary
□ Artery Disease
□ Rheumatic Fever
□ Heart failure
□ High blood pressure
□ High cholesterol
□ Stroke
□ Diabetes
□ Gallstones
□ Liver Disease
□ Hepatitis/Jaundice
□ Ulcer disease
□ Heartburn / Reflux
□ Asthma
□ Seizures
□ Emphysema
□ Pneumonia
□ Tuberculosis
□ Positive TB Skin Test
□ Osteoporosis
□ Arthritis
□ Gout
□ Frequent Bladder Infection
□ Kidney Stones
□ Kidney Disease
□ Polio
□ Chicken Pox
□ Infectious Mono
□ Anemia
□ Frequent Sinus Infections
□ Glaucoma
□ Thyroid Trouble
□ Hives
□ Depression
□ Head Injury
□ Broken Bones
□ Blood transfusions
□ Sexually Transmitted Diseases: Herpes, HIV,
□ Gonorrhea, Chlamydia,
□ Syphilis
□ Intravenous drug abuse
□ Needle injury
□ Mumps
□ Migraines
□ Prostate Enlargement
□ Cystic Fibrosis
□ Malaria
□ Other_____
_____

IMMUNIZATIONS:
□ Measles, Mumps and Rubella Vaccine
□ Chicken pox vaccine
□ Hepatitis B vaccine
□ Influenza vaccine
□ Pneumococcal vaccine
□ Tetanus booster

PAST SURGICAL HISTORY: If yes, please check the box and enter the year.

□ Eyes (Laser or Vision Corrected) ____
□ Eyes (Cataract/Glaucoma) ____
□ Ears ____
□ Sinus/Nasal Septum ____
□ Tonsils/Adenoid ____
□ Thyroid ____
□ Heart ____
□ Stomach ____
□Varicose Veins ____
□ Gall Bladder _____
□ Appendix _____
□ Intestine/Colon _____
□ Hemorrhoids _____
□ Hernia _____
□ Breast _____
□ Uterus/Hysterectomy _____
□ Ovaries _____
□ Spinal Surgery/Neck _____
□ Prostate _____
□ Spinal Surgery/Back _____
□ Orthopedic (Hips/ Knee _____
□ Shoulder/ Feet/Hands) _____
□ C-section _____
_____
□ Vasectomy _____
□ Tubal Ligation _____

□OTHER _____

ALLERGIES and Bad Reactions to Medications: _____ _____

_____ _____

_____ _____

MEDICATIONS: Name Dosage Times a day

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PLEASE ATTACH A COPY OF YOUR MEDICATION/ALLERGY LIST TO THIS FORM

Has anyone in your FAMILY ever had? (**If yes check box and list relationship**)

☐ Cancer & Type	_____	☐ Dialysis	_____	☐ Crohn's/colitis	_____
☐ Diabetes	_____	☐ Chronic lung disease	_____	☐ Alzheimer's	_____
☐ Cardiac Dysrhymthia	_____	☐ Tuberculosis	_____	☐ Alcoholism	_____
☐ Congestive Heart Failure	_____	☐ Rheumatoid Arthritis	_____	☐ Bleeding tendency	_____
☐ Coronary Artery Disease	_____	☐ Thyroid trouble	_____	☐ Anemia	_____
☐ Valvular heart Disease	_____	☐ Osteoporosis	_____	☐ Gout	_____
☐ High Blood Pressure	_____	☐ Cystic Fibrosis	_____	☐ Depression	_____
☐ High Cholesterol	_____	☐ Asthma	_____	☐ Mental illness	_____
☐ Stroke	_____	☐ Peptic Ulcer	_____	☐ Seizures	_____
☐ Kidney stones	_____	☐ Gallstones	_____	☐ Migraine headaches	_____
☐ Kidney disease	_____				
☐ OTHER	_____				

Patient Name: _____

Patient Signature: _____

Patient Date of Birth: _____

Today's Date: _____ (date of visit)

Provider Signature: _____