Vascular Surgical Associates, P.C.

Today's Date: _____ /_____ /_____

Office Use Only:

Chart No. **Employee Init.:**

Patient's Information

Last Name:_____ First Name:_____ MI:_____ Sex: M F

SSN#:_____-_____-_____ Are you a resident of a Skilled Nursing Facility? Yes / No If yes, list facility: _____

Birth Date:_____/_____/_____ Email Address:_____

Street Address: _____ Address Line 2 (i.e. Apt #): _____

City_____ State_____ Zip_____ Marital Status: M S W D

Please check box next to preferred primary telephone number:

☐ Home Ph. #: _____ ☐ Cell Ph. #: _____ ☐ Work Ph. #: _____

_____**By initialing this, I consent to receive text and email appointment reminders and related messages from VSA . I understand that this will apply to all future appointment reminders unless I choose to opt out. I consent to allow VSA to communicate with me via text, email, or phone and I acknowledge that those messages may contain protected health information.**

Usual Provider at VSA.	Referring Physician	Primary Care Physician
_____	_____	_____

Are you a Dialysis Patient? Yes _____ No _____ If so, please list your doctor:_____

Dialysis Center:_____ Phone Number:_____

Emergency Contact Name:_____ Relationship to Patient _____ Phone Number:_____

Patient's Insurance Plan(s) Do you have a Health Savings or Reimbursement Account? Yes / No

Primary Insurance:_____ Policy Number.:_____

Specialist Co-Pay: $_____ Require Referral from PCP: Yes or No Group Number.:_____

Policy Holder Name:_____ Policy Holder Date of Birth:____/____/_____

Secondary Insurance:_____ Policy Number.:_____

Specialist Co-Pay: $_____ Require Referral from PCP? Yes or No Group Number.:_____

Policy Holder Name:_____ Policy Holder Date of Birth:____/____/_____

*Language:*_____ *Race:*_____ *Ethnicity:*_____

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 understand that all charges or co-payments, if applicable are due at the time of services. All profession services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage, unless the services are covered under a contractual agreement between this medical practice and the patient's insurance carrier. I instruct and direct my insurance carrier(s) to pay Vascular Surgical Associates P.C. 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. If transactions are posted on my account that leave a patient credit of less than $1.00, I understand that this will remain on my account for 6 months and be applied to any outstanding patient balance due. After that 6 month period, any credit of less than $1.00 will be adjusted from my account. I understand that Vascular Surgical Associates P.C. utilizes Physician's Assistants for levels of practice approved by the state medical board. I understand and agree to receive services provided by such providers when necessary and appropriate. 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

PATIENT MEDICAL HISTORY INFORMATION

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

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

Do you have, or have you ever had:

High blood pressure	❒ Yes	❒ No
Congestive heart failure	❒ Yes	❒ No
Heart attack	❒ Yes	❒ No
Thyroid disease	❒ Yes	❒ No
Kidney disease	❒ Yes	❒ No
Tuberculosis	❒ Yes	❒ No
Diabetes	❒ Yes	❒ No
Other	❒ Yes	❒ No

Other _____

Stroke	❒ Yes	❒ No
Asthma	❒ Yes	❒ No
Arthritis	❒ Yes	❒ No
Phlebitis	❒ Yes	❒ No
Cancer (type)_____	❒ Yes	❒ No
Varicose veins	❒ Yes	❒ No
Blood clots	❒ Yes	❒ No
Bleeding	❒ Yes	❒ No
Pulmonary embolus	❒ Yes	❒ No

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? ❒ No Have you ever? ❒ Yes ❒ No How much / long? _____

When did you quit? _____ Do you drink? ❒ Yes ❒ No How much? _____

Recreational Drugs? ❒ Yes ❒ No What? _____

Occupation: _____

Are you on dialysis? ❒ Yes ❒ No Who is your dialysis MD? _____

Name of your Dialysis Center: _____

Has anyone in your family ever had any of the following conditions? (Indicate Relationship)

			Mother	Father	Brother	Sister	Maternal Grmother	Maternal Grfather	Paternal Grmother	Paternal Grfather
Cancer	❒ Yes	❒ No								
Diabetes	❒ Yes	❒ No								
High blood pressure	❒ Yes	❒ No								
Aneurysm	❒ Yes	❒ No								
Stroke	❒ Yes	❒ No								
Clotting problems	❒ Yes	❒ No								
Heart Disease	❒ Yes	❒ No								
Kidney Disease	❒ Yes	❒ No								

Are you currently experiencing any of the following symptoms?

General

Chills	❒ Yes	❒ No
Fatigue	❒ Yes	❒ No
Fever	❒ Yes	❒ No
Tiredness	❒ Yes	❒ No
Weight gain	❒ Yes	❒ No
Weight loss	❒ Yes	❒ No

ENT

Visual loss	❒ Yes	❒ No
Hearing loss	❒ Yes	❒ No
Mouth sores	❒ Yes	❒ No
Swallowing difficulties	❒ Yes	❒ No

Cardiac

Chest pain	❒ Yes	❒ No
Pain in feet when walking	❒ Yes	❒ No
High blood pressure	❒ Yes	❒ No
Irregular heart beat	❒ 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	❒ Yes	❒ No
Vomiting	❒ Yes	❒ No
Constipation	❒ Yes	❒ No
Diarrhea	❒ Yes	❒ No

Endocrine

Appetite changes	❒ Yes	❒ No
Cold intolerance	❒ Yes	❒ No
Excessive thirst	❒ Yes	❒ No
Heat intolerance	❒ Yes	❒ No

I have tested positive for the following (please check any that apply):

❑ HIV ❑ Hepatitis B ❑ Hepatitis C

❑ C-Diff ❑ Other (specify) _____

Genitourinary

Blood in urine	❒ Yes	❒ No
Frequent urination	❒ Yes	❒ No
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

Burning of toes, feet, hands	❒ Yes	❒ No
Clumsiness	❒ Yes	❒ No
Difficulty speaking	❒ Yes	❒ No
Headaches	❒ Yes	❒ No
Numbness / tingling	❒ Yes	❒ No
Seizures	❒ Yes	❒ No
Arm / leg weakness	❒ Yes	❒ No

Psychiatric

Depression	❒ Yes	❒ No
Insomnia	❒ Yes	❒ No
Nervousness	❒ Yes	❒ No

Hematological / Lymphatic

Blood clotting problems	❒ Yes	❒ No
Enlarged lymph nodes	❒ Yes	❒ No
Genetic factors	❒ Yes	❒ No
Prolonged bleeding	❒ Yes	❒ No

_____ _____

Patient Signature Date

Print Name _____