Vascular Surgical Associates

Today's Date:_____ /_____ /_____

Office Use Only:

Chart No. **Employee Init.:**

Patient Information

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

SSN:_____-_____-_____ Are you a resident of a Skilled Nursing Facility? Yes / 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 copayments, 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 $5.00, 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 $5.00 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 P.C.

Patient Pharmacy Form

Patient's name: _____ **Date of birth:** _____

MEDICAL CONSENT FORM: Pharmacy: _____

Phone # or Street Name: _____

Mail in Pharmacy (if applicable)_____

ID#_____Phone #_____

___ I authorize Vascular Surgical Associates, PC, to obtain information regarding my current prescriptions.

___ I **do not** authorize Vascular Surgical Associates, PC, to obtain information regarding my current prescriptions.

_____ _____

Signature **Date**

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	Stroke	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No	Cancer (type)_____	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Varicose veins	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Blood clots	☐ Yes	☐ No
Other	☐ Yes	☐ No	Bleeding	☐ Yes	☐ No
			Pulmonary embolus	☐ Yes	☐ No
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? ☐ 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)

							Maternal		Paternal	
			Mother	Father	Brother	Sister	Grmother	Grfather	Grmother	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 all 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 Pregnacies

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, feat, 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_____