VSA Prosthetics Center

PATIENT INFORMATION

(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: _____

Employer: _____ Employer Phone: ( )_____

Social Security No.: _____/ _____/ _____ Marital Status: Married Single Divorced Widowed

Spouse:_____ SS#: _____/ _____/_____ Date of Birth: ___/___/___

Emergency Contact:_____ Address:_____ Phone #: ( ) _____

Primary Care Physician:_____ Phone #: ( ) _____

Allergies:_____ Height:_____ Weight:_____

Referring Physician:_____ **Phone #: ( ) _____**

Are you a dialysis patient? Yes No If so, please list your doctor _____

Dialysis Center:_____ **Phone #: ( ) _____**

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

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

IMPORTANT INFORMATION

PLEASE READ CAREFULLY: All charges or co-payments, if applicable, are due at the time of services. All professional 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 your insurance carrier.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Vascular Surgical Associates P.C. or its physicians to release any information acquired in the course of my examination or treatment to: (Insurance Company or Attorney). A copy of this authorization shall be considered as valid as an original.

I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration and Health Care Financing Administration or to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to either myself or to the party who accepts assignment. I understand that I am responsible for any amount not covered by my insurance.

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_____

Vascular Surgical Associates, P.C.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Vascular Surgical Associates, P.C. to disclose the following information from the health records of:

Name:_____
Last First MI Previous Name

Birthdate: _____ **Account number#:**_____

Telephone: _____

Address: _____
Street City State Zip

This information is to be disclosed only to (list any relatives or friends who are allowed access to your information):

1._____ **3.**_____

2._____ **4.**_____

Covering (Date(s) of service):

From (date)_____**to (date)**_____ **or**

_____ **All dates of service (please initial if all dates desired)**

For the purpose of _____

The following information may be released:

_____

I understand that this will include information relating to (check and initial only if applicable):

- ☐ **Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection.**
- ☐ **Behavioral health service/psychiatric care.**
- ☐ **Treatment for alcohol and/or drug abuse.**

Affirmation of Release: I give Vascular Surgical Associates, P.C. permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations.

Signature of the Patient/Guardian/Legal Representative **Date Signed**

_____ _____

Vascular Surgical Associates, P.C.

Acknowledgement of Recept of Privacy Practices

I, _____ have received a copy of of Vascular Surgical Associates, P.C. Notice of Privacy Practices.

_____
Date

_____
Print Name

_____
Signature

OFFICE USE ONLY

On _____ 20___ at _____ (AM/PM) we made a good faith attempt to obtain a written acknowledgement of receipt of our NPP, but acknowledgement cound not be obtained because of the following reasons:

_____ Patient refused to sign

_____ Communication barriers prevented obtaining a receipt

_____ An emergency prevented obtaining a receipt

_____ Other: _____