

Today's Date: ____/____/____

Office Use Only:	
Chart No. _____	Employee Init.: _____

Patient's Information

Last Name: _____ First Name: _____ MI: _____

SSN#: _____ - _____ - _____ Marital Status: M S W D

Street Address: _____ Home Telephone: _____

Work Telephone: _____

City: _____ Cell Number: _____

State: _____ Zip Code: _____ Sex: M F Birth Date: ____/____/____

<p>You are now able to view your chart on our PATIENT PORTAL- FOLLOW MY HEALTH You will receive an email tomorrow for you to be able to send messages and view/download documents from your chart.</p>	<p>E Mail: _____</p>
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Usual Provider at Vascular Surgical, P.C. _____ Referring Physician _____ Primary Care Physician _____

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

Emergency Contact Name: _____ Phone No: _____

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

Primary Insurance: _____ Policy No.: _____

Specialty Co-Pay: \$ _____ Require Referral from PCP: Y N Group No.: _____

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

Secondary Insurance: _____ Policy No.: _____

Specialty Co-Pay: \$ _____ Require Referral from PCP: Y N Group No.: _____

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. 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: ____/____/____

NAME _____

D.O.B. _____

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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
- Pain in feet at rest 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
- Thyroid disease Yes No
- Diabetes Yes No

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

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

- HIV
- Hepatitis B
- Hepatitis C
- C-Diff
- Other (specify) _____

Patient Signature

Date

Print Name