

PATIENT INFORMATION

Full Name: _____ **Date of Birth:** _____ **Date:** _____
 (First) (Middle) (Last)

Gender: Male Female **Marital Status:** Single Married Divorced Widowed

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone #: _____ **Cell Phone #:** _____

Email Address: _____ **Preferred Language:** _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown/Declined

Race: Asian American Indian African American Native Hawaiian/Pacific Islander
 White Hispanic or Latino Other Unknown/Declined

Documents: None Advanced Directive Power of Attorney Living will/ Living Trust Do Not Resuscitate
 Do Not Intubate

Emergency Contact Information:

Name: _____ **Relationship:** _____ **Phone:** _____

Referring Physician's Information

Physician's Name: _____

Physician's Address: _____

Physician's Phone #: _____ **Physician's Fax #:** _____

Primary Care Physician's Information

Physician's Name: _____

Physician's Address: _____

Physician's Phone #: _____ **Physician's Fax #:** _____

Insurance Information

Primary Insurance: _____ **Certificate #:** _____

Group #: _____ **Group Name:** _____ **ID #:** _____

Secondary Insurance: _____ **Certificate #:** _____

Group #: _____ **Group Name:** _____ **ID #:** _____

Pharmacy Information

Pharmacy Name: _____ **Address:** _____

Phone #: _____ **Fax #:** _____

Dialysis Information

Not Applicable

Dialysis Center: _____ **Address:** _____

Phone #: _____ **Fax #:** _____

Dialysis Days (please circle): Mon Tue Wed Thur Fri Sat Sun **Contact Name:** _____

Past Medical History (please circle answer):

Condition			Year of Onset
Coronary Artery Disease	Yes	No	
Diabetes	Yes	No	
Hypertension	Yes	No	
Stroke	Yes	No	

Condition			Year of Onset
Chronic Renal Failure	Yes	No	
High Cholesterol	Yes	No	
Obesity	Yes	No	
COPD (Chronic Obstructive Pulmonary Disease)	Yes	No	

Past Surgical History (including hospitalization and cardiovascular procedures):

Surgery Type	Date	Doctor/Hospital

Allergies: Yes No _____

Social History:

 Do you smoke? Yes No How much? _____
 Are you a former smoker? Yes No Year quit: _____
 Do you drink alcohol? Yes No Frequency? _____

Family History (Please circle answer if your immediate/blood relatives had the following conditions)

Condition			Family Member
Coronary Artery Disease	Yes	No	
Diabetes	Yes	No	
Hypertension	Yes	No	
Stroke	Yes	No	
Bleeding Tendency	Yes	No	
Varicose Veins	Yes	No	

Condition			Family Member
Cancer	Yes	No	
High Cholesterol	Yes	No	
Obesity	Yes	No	
Gout	Yes	No	
Arthritis	Yes	No	
Peripheral Artery Disease	Yes	No	

Medication List:

Medication Name	Dose / Frequency

Medication Name	Dose / Frequency

Review of Systems (Check all that you are currently experiencing):

CARDIOVASCULAR		GENITOURINARY:		PSYCHIATRIC:	
<input type="checkbox"/>	Chest pain or palpitations	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Burning/painful urination	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Difficulty walking two blocks	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	Hallucination
<input type="checkbox"/>	heart murmur	<input type="checkbox"/>	Kidney stones	ENDOCRINE:	
EARS, EYES, NOSE, THROAT		MUSCULOSKELETAL:		<input type="checkbox"/>	Excessive thirst
<input type="checkbox"/>	Do you wear glasses?	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	Change in vision	<input type="checkbox"/>	Joint swelling	<input type="checkbox"/>	Intolerant to heat/cold
<input type="checkbox"/>	Change in hearing	<input type="checkbox"/>	Injuries to joint	HEMATOLOGIC:	
<input type="checkbox"/>	Frequent sneezing	<input type="checkbox"/>	fractures	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Nosebleeds	SKIN:		<input type="checkbox"/>	Excessive bleeding
RESPIRATORY:		<input type="checkbox"/>	Hives	<input type="checkbox"/>	Excessive bruising
<input type="checkbox"/>	Shortness of breath while walking	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Swollen glands
<input type="checkbox"/>	Cough	<input type="checkbox"/>	Rash	IMMUNOLOGY/ALLERGY:	
<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Abnormal pigmentation	<input type="checkbox"/>	Itchy eyes
GASTROINTESTINAL:		NEUROLOGICAL:		<input type="checkbox"/>	Runny noses
<input type="checkbox"/>	Bloody bowel movements	<input type="checkbox"/>	Fainting spells	GENERAL:	
<input type="checkbox"/>	Recent change in bowel habits	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Fevers or chills
<input type="checkbox"/>	Frequent diarrhea	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	Heartburn or indigestion	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Recent weight change

I understand that the above information is required to provide me with the proper medical care in a safe and effective manner. I have completed the questions to the best of my knowledge. Should further information be needed, I give my consent to ask the respective healthcare provider agency to release any necessary information. I will notify the doctor of any changes in my health or medication.

Patient Name (Print) _____

Patient or Guardian/Legal Representative Signature _____

Date _____

Disclosure of Protected Health Information

I have been provided and have reviewed the Notice of Privacy Practice which provides a complete description of the uses and disclosures of certain medical information. I understand that as part of the provision of medical services, Paik Vascular & Vein Center creates and maintains health records (in written, oral, or electronic format) for medical treatment, payment, health care operations, and all other purposes outlined in the Notice of Privacy Practice.

_____ (initials) I authorize the release of any medical information necessary to process any claim. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance company or me at any time, in writing, except where disclosure have already been made on my prior consent.

Notice of Financial Responsibility

I have been provided and have reviewed the Notice of Patient Financial Responsibility which describes my financial obligations. I understand that Paik Vascular & Vein Center will submit billing for medical services, as a courtesy, to my insurance carriers but I am ultimately responsible for the payment for all medical services provided.

_____ (initials) I understand that I am financially responsible to the physician for all charges.

Patient Name (Print)

Patient or Guardian/Legal Representative Signature

Date

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY/E-PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety.

By authorizing Paik Vascular & Vein Center, you allow us to view your external prescription history. This will provide the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and staff here, and it may include prescriptions back in time for several years.

By signing this consent form, you are agreeing that Paik Vascular & Vein Center can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Patient Name (Print)

Patient or Guardian/Legal Representative Signature

Date



PATIENT ACKNOWLEDGEMENT OF PROCEDURE REGISTRATION DOCUMENTS

I _____ (patient name) acknowledge I have reviewed and agree with the following documents presented to me during the Procedure Registration process.

- Policy on Advance Directions
- Disclosure of Physician Ownership
- Patient Financial Responsibility
- Patient Rights and Responsibilities
- Acknowledgement of HIPAA Compliance
- Consent for wound/vascular Photographs or Images
- Patient Demographics

Best 2 phone numbers to reach me at for a followup call

Ph.1 _____ Ph. 2 _____

Patient or Legal Representative Signature

Date