Vascular & Surgical Care Northwest

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Appointment Date: ___________________________

Name (First, MI, Last)**:** _____________________________

Address: ___________________________________

City ___________________ **State** _____ **Zip** ________

Phone: ________________________CELL/WORK/HOME

Alternate Phone: ________________CELL/WORK/HOME

Email: _____________________________________

Contact preference: Phone / Alt. Phone / Email

Employer: __________________________________

Occupation: _____________________________

Workers Compensation Claim: YES / NO

Reason for visit today: ________________________

____

MRN: __________________________________

Primary Doctor: _____________________________

Referring Doctor: ____________________________

Nephrologist: _______________________________

Cardiologist: _______________________________

Gender: M / F **Birth Date:** _________________

Marital/Partner Status:________________________

RACE: ______________________ ☐ **Refuse to answer**

ARE YOU OF HISPANIC ORIGIN?

☐ **YES** ☐ **NO** ☐ **Refuse to answer**

NATIONALITY: _______________ ☐ **Refuse to answer**

Emergency Contact: (Phone) _______________________

(Name) ______________________________________

(Relationship) _________________________________

Primary Insurance: ____________________________

Address: __________________________________

Insurance ID: _______________________________

Group ID: ___________________________________

Subscriber: _________________________________

Relationship: ________________________________

Secondary Insurance: _________________________

Address: __________________________________

Insurance ID: ______________________________

Group ID: __________________________________

Subscriber: ________________________________

Relationship: _______________________________

DO YOU CURRENTLY DO OR HAVE THE FOLLOWING?

CAFFEINE	_____ Cups per day	
PACE MAKER	☐NO	☐YES (PLEASE PROVIDE A COPY OF PACEMAKER CARD)
ALCOHOL	☐NO	☐YES: ______ per day ______ per week
TOBACCO	☐NO	☐YES: ______ PACKS PER DAY ☐QUIT
RECREATIONAL DRUGS	☐NO	☐YES
HEART ATTACK	☐NO	☐YES
HIGH BLOOD PRESSURE	☐NO	☐YES
HIGH CHOLESTEROL	☐NO	☐YES
ANEURYSM	☐NO	☐YES
DIABETES	☐NO	☐YES
FIBROMUSCULAR DYSPLASIA	☐NO	☐YES

OTHER MEDICAL CONDITIONS:

When was your last Echo/ Stress test? _______________ **Where?** ____________________________

SYSTEM REVIEW (PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS)

- ☐ Fainting/ Passing out
- ☐ Seizure
- ☐ Hearing Changes
- ☐ Extreme Weight Change
- ☐ Unexplained Fever
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Rashes/ Itching
- ☐ Cold Extremities
- ☐ Memory Changes
- ☐ Headaches/Dizziness
- ☐ Chest Pain
- ☐ Heart Disease
- ☐ Heart Palpitations
- ☐ Varicose Veins
- ☐ Blood in Urine
- ☐ Kidney Trouble
- ☐ C. Diff
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Change in Bowel Habits
- ☐ Diabetes
- ☐ Heat/ Cold Intolerance
- ☐ Non-Healing Wounds
- ☐ Daily Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Leg Swelling
- ☐ Muscle Weakness
- ☐ Fibromuscular Dysplasia
- ☐ Joint Pain/ Swelling
- ☐ Vision Changes
- ☐ Blood Clots
- ☐ MRSA
- ☐ Excessive Bleeding/ Bruising
- ☐ Vancomycin Resistant Enterococcus

PREVIOUS SURGERIES AND/OR HOSPITAL STAYS (NAMES & DATES)	

FAMILY MEDICAL HISTORY (PLEASE INDICATE RELATIVE WITH CONDITION)

Peripheral Artery Disease		**Diabetes**		**Vein Troubles**	
Stroke		**Fibromuscular Dysplasia**		**Cancer:** _______________	
Heart Attack		**High Blood Pressure**		**Other:** _______________	
Heart Trouble		**Cholesterol**			
Aneurysms		**Kidney Trouble**			

I give my consent for services to be rendered by Vascular & Surgical Care NW, PLLC and its staff. I hereby authorize Vascular & Surgical Care NW, PLLC to release all information necessary to secure payment of said benefits. I understand that I am financially responsible for all charges incurred. I hereby assign all medical benefits to which I am entitled to be paid directly to Vascular & Surgical Care NW, PLLC. To the best of my knowledge, the information given is true and correct.

____ Today's Date _______________

Signature of Patient/Responsible Party

PRINT NAME IF PERSON SIGNING IS NOT THE PATIENT ______________________________________

RELATIONSHIP ____________________________________

NAME: ____ **DATE OF BIRTH:** ______________

PHARMACY NAME: ____________________________________

PHARMACY PHONE: ___________________________________

DRUG ALLERGIES: ____

MEDICATION NAME	DOSAGE	FREQUENCY	AM/NOON/PM/BEDTIME

PLEASE ATTACH ADDITIONAL SHEET IF NEEDED

Date: ________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PORTABLILITY AND ACCOUNTABILITY ACT

PATIENT NAME (print): ____DOB: __________________

By my signature below, I ______________________________________ acknowledge that I **received** a copy of the Notice of Privacy Practices for Vascular & Surgical Care NW, PLLC.
This authorization grants permission to the Designated Party (ies) named below to exchange my private medical information with Vascular & Surgical Care NW, PLLC, and any authorized representative thereof, without restriction in terms of content, purpose, or means of transmission. This authorization includes, but is not limited to: making or confirming appointments; accessing any and all imaging, laboratory, or test information; access to telephone communication and answering machine messages as well as other common means of communication; be made aware of my diagnosis, prognosis, and treatment plans; direct discussion of my health with my doctor or other provider; and have access to my financial information as it relates to my health.

NAME OF DESIGNATED PARTY	RELATIONSHIP	PHONE NUMBER

Signature of Patient: ____ Date: ______________
If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: ____
Relationship to Patient: ____