CONFIDENTIAL HEALTH HISTORY

Name: _____ DOB: _____

Who referred you to our office: _____

Primary Care Physician (PCP): _____

Nephrologist/Kidney doctor: _____

Have you ever had any of the following (circle all that apply)

Aneurysm (where):_____
Alcoholism
Anemia
Asthma
Bleeding Disorder
Blood Transfusion
Bronchitis
Cancer (where): _____
Cataracts
COPD
Diabetes
Drug Dependency
DVT/Blood clot
Emphysema
Epilepsy/Seizures
Esophageal Reflux
GERD
Glaucoma
Gout
Heart Attack
Heart Rhythm Problem
Heart Valve Disorder
Hepatitis (kind): _____
Hernia
HIV Positive
High Cholesterol
High Blood Pressure
Kidney Disease
Kidney Dialysis
Liver Disease
Pacemaker
Phlebitis
Pneumonia
PVD/Circulation Problem
Rheumatic Fever
Stroke
Thyroid Disease
Tuberculosis
Ulcer
Varicose Veins
NONE
OTHER: _____

List all Surgeries and Procedures (If you brought a list, we will copy it instead of filling out this section)

Surgery/Procedure	Year Performed	Surgery/Procedure	Year Performed

Please list all medication allergies and the reaction

Allergic to:	Reaction	Allergic to:	Reaction

List all medications and supplement you take regularly (If you brought a list, we will copy it instead of filling out this section)

Medication	Dose	Frequency (how often)	Prescribing Physician (or over the counter

Family History

Has any blood relative had any of the following? Circle the problem and indicate which relatives for example, "paternal grandmother"

PROBLEM	FAMILY MEMBER	PROBLEM	FAMILY MEMBER
Aneurysm-what kind?		High Cholesterol	
		High Blood Pressure	
Cancer-what kind?		Kidney Disease	
		Stroke	
Heart Disease- what kind?		OTHER	

Social History

Marital Status Single Married Divorced Widowed In a Relationship

Retired? Yes No What is your current occupation? _____

Disabled? Yes No Do you live alone? Yes No

With family? Yes No Name: _____ Relation: _____

In an assisted living facility or nursing home? Yes No Name: _____

Do you smoke? Never Former- when? _____ How much? _____ How many years? ____
Current- How much per day? _____

Do you drink alcohol? Never Former-when? _____ Current- How much per day? _____

Do you use illegal drugs? Never Former-when? _____ Yes, what kind, how much and how often?
_____

PATIENT INFORMATION SHEET

CONFIDENTIAL Please Print

Patient Name: _____
First Middle Last

Date of Birth: _____ Age: _____ Gender: _____ Social Security #: _____

Home Address: _____
Street City State Zip

Home Phone :(_____)_____ Cell Phone: (_____)_____

Dialysis center: _____ Days (circle) M T W R F SAT Time: _____

Pharmacy Name: _____ City: _____ Phone: _____

Email Address: _____
(Patients with cell phones and/or emails will be sent appointment reminders by text and/or email.)
Primary Language: _____ Race: _____ Ethnicity: _____

Referring Physician: _____
Name Address City/State/Zip Phone

Primary Physician: _____
Name Address City/State/Zip Phone

Due to Federal HIPAA regulations Vascular Specialists, LLC may not release any of your information regarding your condition without your permission. In the spaces provided, please designate family members and/or persons to whom we may discuss and/or release information relative to your medical condition and sign below. This/These persons may also be listed as emergency contacts.

I, _____ give Vascular Specialists, LLC and any of its representative's permission to discuss and/or release my personal and private medical information to/with those who I have listed below.

_____
Name Address City/State/Zip Phone
Relationship _____

_____
Name Address City/State/Zip Phone
Relationship _____

✖ Patient Signature: _____ Date: _____

COPIES OF INSURANCE CARDS AND DRIVER'S LICENSE OR STATE ISSUED ID ARE REQUIRED FOR BILLING PURPOSES ONLY.

I request that payment of authorized Medicare benefits and Medigap insurance, or any medical insurance program (Commercial insurance) to be made payable to Vascular Specialists, LLC for any services provided to me by its associated physicians or allied health professionals. I authorize any holder of medical information or other information necessary to process claims on my behalf be released to our billing company and its agents needed to determine benefits or benefits for related services. I also authorize that the use of a copy of this authorization in place of the original. I understand that I am financially responsible for any amounts not paid by insurance (after appropriate adjustments are made). I understand and agree to these conditions as a patient of this medical practice.

Patient Signature: _____ Date: _____

✖ **nature of Patient Representative: _____ Date: _____**
(Required if patient is unable to sign)

Vascular Specialists

OFFICE POLICY

We understand that situations arise in which you must cancel your appointment or surgery. It is therefore requested that if you must cancel your office appointment you provide more than 24 hours' notice. This will allow another person who is waiting for an appointment to be scheduled in the appointment slot.

Any patient that is scheduled for a surgery or procedure at the hospital is subject to a **$50.00** cancellation fee if the office is NOT notified within 5 business days and documentation of the reason such as a doctor's note.

Any patient that is scheduled for an office procedure is subject to a **$50.00** cancellation fee if the office is NOT notified within 3 business days and documentation of the reason such as a doctor's note. This also applies to patients who do not show for the office procedure.

Office appointments and/or ultrasound appointments which are cancelled with less than 24-hour notification may be subject to a **$25.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as **NO SHOW**. Patients who NO-SHOW three (3) or more times in a 3-month period, may be dismissed from the practice thus they will be denied any future appointments.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

In order to provide the best care, under certain circumstances you may see another physician in the group for office appointments and/or procedures.

Please be advised co- payments are due at the time of check- in. Failure may result in rescheduling appointment. In the event there is a financial hardship, please consult with a staff member to further discuss options regarding outstanding balance(s).

At this time, please note our office has a **strict on time policy**. Tardiness may result in rescheduling appointment. We apologize for any inconvenience.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department (815-824-4406 option 3)

Please sign that you have read, understand, and agree to this Cancellation and No-show policy.

Patient Name	**Date of birth**
Signature of Patient or Patient Representative	**Date**