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)

Office Policy

We strive to provide the best quality care to our patients. To make sure this is possible, we adhere to a set of important guidelines. Please read them carefully, initial all the lines and indicate your agreement by signing the bottom of the form.

_____ **Late Policy:** Please arrive 15 minutes prior to your scheduled appointment to complete/update your registration form(s). Being late for your appointment may require you to either reschedule or wait for an available opening. There are no guarantees since openings due to cancellations or no-shows are unpredictable.

Cancellation and No-Show Policy

_____ **Surgical:** Any surgical procedure scheduled to be performed at a hospital is subject to a **$50** cancellation fee, if the office is not notified within 5 business days, or documentation such as Doctors note is not provided as reason for cancellation.

_____ **Procedures (In Office):** Any procedure scheduled in office is subject to a **$50** cancellation fee if the office is not notified within 72 hours or documentation such as a doctor's note is not provided as reason for cancellation.

_____ **Office appointments/Ultrasound appointments:** Any office appointment/or Ultrasound that is not cancelled with 24 hours' notice will be subject to a **$25** cancellation fee.

_____ **Patients who do not show for their scheduled appointment, (3) or more times within in a 3-month period, may be subject to dismissal from Vascular Specialists, and will be denied any future appointments.** We understand special unavoidable circumstances may cause you to cancel appointments. Fees in this instance may be waived but only with management approval.

The Cancellation and No-Show fees are the sole responsibility of the patient. We must ask that payment is made on these fees before new appointments are made.

Insurance/Co-Pay Policy

_____ **Insurance cards are required to be presented at every visit. Failure to make co-payment at the visit may result in cancellation of the scheduled appointment.** Patients are responsible for charges not covered by their insurance.

_____ **Balances on account from previous services provided will require payment, or a payment arrangement can be made with our Billing Department by calling (815-824-4406 opt 4)**

To provide the best care, under certain circumstance you may see another physician in the group for office appointments or procedures.

_____ _____

Patient Name **Date of birth**

_____ _____

Signature of Patient or Patient Representative **Date**