VASCULAR EXPERTISE. PERSONALIZED AND CONVENIENT

You can complete this form on your computer and then print it, sign it and bring it with you to your appointment.

Today's Date: ________________________ Account # ________________________ Male: ☐ Female: ☐

Name: ____ Birth Date: ____________ Age: _________

Address: ____

City/Town: _______________________________ State: _____________________ Zip Code: ________________

Phone: _______________________ Cell: _________________________ Work Phone: ______________________

E-mail Address: ____

If you do not wish to share your email or if you do not have an email, please initial ______________________

Language: ________________________ **Race:** _______________________ **Ethnicity:** ______________________

Work, circle one: ☐F/T ☐P/T ☐Retired ☐Unemployed

Marital Status, circle one: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Emergency Contact:

Name: ____________________________Relation: ____________________ Phone #: ______________________

Primary Care Physician: ____

Address: ____ Phone #: ___________________________

Referring Physician: ____

Address: ____ Phone # ______________________________

Cardiologist: ____

Address: ____ Phone # ___________________________

Podiatrist: ____

Address: ____ Phone # ___________________________

Patient's Name: ___________________________________ Date: ________________

Pharmacy: ______________________ City ___________________State______ Phone #: _______________

Pharmacy Address: ____

Insurance Information

Primary Insurance: _____________________________________ Copay Amount: ____________________

Identification#: _____________________________________ Group#: _____________________________

Policy Holder: ____ DOB: ________________

Employer: _____________________________ Employer's Address: ________________________________

Insurance Referral Required: Yes☐ No☐ Obtained: Yes☐ No☐

Secondary Insurance: ___________________________________ Copay Amount: ____________________

Identification#: ____ Group#: __________________________

Policy Holder: ____ DOB: ___________

Employer: __________________________________ Employer's Address: ___________________________

Insurance Referral Required: Yes☐ No☐ Obtained: Yes☐ No☐

Guarantor:______________________________

Dialysis Information

Please Check: ☐Hemodialysis ☐Peritoneal dialysis ☐Pre dialysis

Hemodialysis days: ☐M/W/F ☐T/T/S ☐Other: ________________________________

Dialysis Center Name: ____

Address:____ Phone #: ___________________________

Hemodialysis Access: ☐left arm ☐right arm ☐left leg ☐right leg ☐catheter

Patient's Name: ___________________________________ Date: ______________

Medical Information

Height: _________ Weight: ________

Do you now or have you ever had any of the following, circle yes or no:

Angina	☐Yes ☐No	Dialysis Status	☐Yes ☐No
Aneurysm	☐Yes ☐No	Heart Attack	☐Yes ☐No
AVM	☐Yes ☐No	High blood pressure	☐Yes ☐No
Asthma	☐Yes ☐No	Kidney Stones	☐Yes ☐No
Atrial Fibrillation	☐Yes ☐No	PVD	☐Yes ☐No
COPD	☐Yes ☐No	Raynaud's Disease	☐Yes ☐No
CHF	☐Yes ☐No	Renal Disease	☐Yes ☐No
Diabetes, Type 1	☐Yes ☐No	Stroke	☐Yes ☐No
Diabetes, Type 2	☐Yes ☐No	Phlebitis	☐Yes ☐No
Diabetic Neuropathy	☐Yes ☐No	Thyroid disorder	☐Yes ☐No
High Cholesterol	☐Yes ☐No	Varicose Veins	☐Yes ☐No
DVT (blood clot)	☐Yes ☐No	HIV/AIDS	☐Yes ☐No

Surgical History

Please select:

☐None	☐Carotid endarterectomy (L/R)	☐Bypass graft
☐Stent placement	☐Stab phlebectomy	☐Vein stripping
☐Aortic aneurysm repair	☐Dialysis access (AVF/AVG)	☐Left above knee amputation
☐Vein ablation	☐Heart stents	☐Hip replacement (L/R)
☐Heart surgery	☐Above knee amputation (left/right/both)	☐Below knee amputation (left/right/both)
☐Knee replacement (L/R)		

Do you have a pacemaker? ☐No ☐Yes, please give implant card to the front desk
If yes: Make __________________ Model _______________ Serial # ____________________

Do you smoke: ☐Yes ☐No Have you ever: ☐Yes ☐No
If you still smoke, how much do you smoke? _______ packs/day. How many years? __________

Consumption of alcoholic beverages (please check one):
Regularly☐ Socially☐ None at all☐ Occasional☐

Has anyone in your family had the following, circle yes or no:

Diabetes	☐Yes ☐No	Relationship ____________
Heart Disease	☐Yes ☐No	Relationship ____________
Clotting Issues	☐Yes ☐No	Relationship ____________
Varicose Veins	☐Yes ☐No	Relationship ____________
Aneurysm	☐Yes ☐No	Relationship ____________

Other family medical/surgical information:
____.

Patient's Name: ___________________________________ Date: ____________________

Medication Name:	Dosage:	Frequency:

Please select if you take any of the follow blood thinning medications:

☐Aspirin 81mg (baby) ☐Aspirin 325mg (full) ☐Plavix (Clopidogrel)
☐Coumadin (Warfarin) ☐Xarelto ☐Pradaxa
☐Eliquis ☐Effient ☐Brilinta

Allergies

Drug Allergies: ____

Food/Environmental/Substance Allergies:____

Have you had an adverse reaction to any of the following, what type of reaction:

Shellfish ☐Yes ☐No ____________________ Cat Scan Dye ☐Yes ☐No ____________________
Adhesives ☐Yes ☐No ____________________ Betadine ☐Yes ☐No ____________________
Latex ☐Yes ☐No ____________________

Patient Name: ______________________________________

Acknowledgement of HIPAA Privacy Notice

I acknowledge that I have been provided with a copy of The Vascular Experts of Southern Connecticut Vascular Center's privacy notice.

Please sign: ____
Date

Consent to Treat

My signature below represents my consent to treat for any provider in The Vascular Experts of Southern Connecticut Vascular Center, LLC.

Please Sign: ____
Date

Disclosures to Family Members, Friends and Personal Representatives

I understand that HIPAA allows me to name a family member(s), friend or any other person I identify as someone to whom The Vascular Experts of Southern Connecticut Vascular Center may disclose my personal health information. I understand that such disclosures shall be limited to the health information that is directly relevant to the named person's involvement with my healthcare or payment for my healthcare. I also understand that The Vascular Experts of Southern Connecticut Vascular Center will follow stringently the guidelines set forth by HIPAA under the policies and procedures as outlined in the "Disclosures to Family Members, Friends and Personal Representatives" guidelines and that if I request one, The Vascular Experts of Southern Connecticut Vascular Center will provide me with a copy of these guidelines for reference purposes.

Please release and/or discuss my care (PHI) with the individuals named below:

1. _____________________________________ Relation________________________
2. _____________________________________ Relation________________________
3. _____________________________________ Relation________________________

Please Sign: ____
Date

Communications via Cellular Phone and/or Email

If you have provided a cellular telephone number and/or email address as a primary contact method. I hereby authorize, The Vascular Experts of Southern Connecticut Vascular Center, along with respective employees, agents and business associates, to contact me via cellular phone, text message or email for any reason. Including, without limitation, feedback surveys, automated notifications, appointment reminders, health wellness and prevention opportunities. Debt collection agencies may engage, to place calls to your designated cellular or residential phone using any type of artificial or pre-recorded voice or auto-dialer technologies for any purpose permitted by law.

Please Print and Sign: ____
Date