SAN ANTONIO VASCULAR AND ENDOVASCULAR CLINIC

NEW PATIENT REGISTRATION FORM

Patient's Name: _____ **Date of Birth**: _____ Age: _____

Reason for Visit: _____

Social Security #: _____-_____-_____ **Your social security number is strictly confidential and will solely be used for billing purposes*

Sex: ☐ Male ☐ Female Marital Status: ☐Single ☐Married ☐Widowed ☐ Divorced

Spouse: _____

Home Phone:_____ **Cell Phone**: _____ Work Phone: _____

Emergency Contact: _____Relation:_____

Home Address: _____

Where/whom do you live with? ☐ Home ☐ Family ☐ Nursing Home ☐ other_____

Race (optional): ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander

Employment: ☐FT ☐PT ☐ Retired ☐ Not Employed ☐Active Military Duty ☐ Other: _____

Occupation: _____

Employers Address:_____

Do you have an Advanced Directive/DNR? (Documents describing your choice of care for any Health Emergency)

☐ No ☐ Yes, List them: _____

Do you have a medical Power of Attorney? ☐ No ☐ Yes, Name: _____

Email address: _____

☐Yes, I would like to receive online access to my medical records through Patient Portal

☐No, I would not like to receive online access to my medical records

INSURANCE:

Primary

Name: _____
ID: _____
Guarentor: _____
Date of Birth: _____

Secondary

Name: _____
ID: _____
Guarentor: _____
Date of Birth: _____

Other Coverage: _____

SAN ANTONIO VASCULAR AND ENDOVASCULAR CLINIC

Patient Name:_____ **Date:** _____

Past Medical History

*Please circle any of the following that apply to you:** INCLUDE DATE OR YEAR***

Diabetes- On insulin, pills or diet? ☐ Yes ☐ No

High blood pressure	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Poor Circulation	☐ Yes ☐ No
Heart Attack/		Other Heart Problems	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No		
Stroke/TIA	☐ Yes ☐ No	*specify*: _____	
Kidney problems	☐ Yes ☐ No	Lung problems	☐ Yes ☐ No

Other: _____

Do you have any prosthetics or implants? ☐ Yes ☐ No Specify: _____

Do you have a pacemaker? ☐ Yes ☐ No

Have you ever had any of the following tests?

Stress Test on the heart? ☐ Yes ☐ No When/Where? _____

MRI or CT scan? ☐ Yes ☐ No When/Where? _____

Angiogram of blood vessels? ☐ Yes ☐ No When/Where? _____

Lung function test/pulmonary function test?

☐Yes ☐ No When/Where? _____

Heart catheterization/angiogram?

☐ Yes ☐ No When/Where? _____

Preferred Pharmacy Name and Phone #: _____

Please list all medications you are taking:

*** If you brought in your list of medication or hand carried vials- SKIP THIS BOTTOM PORTION ****

** Please include other medications such as aspirin, herbs, insulin, eye drops & vitamins*

Medication	Dose	How Often Do You Take This?	What is it Taken for?

Have you had a flu shot? ☐ Yes – When? _____ ☐ NoPlease list any other recent immunizations: _____

SAN ANTONIO VASCULAR AND ENDOVASCULAR CLINIC

Patient Name: _____ **Date:** _____

Social History

Alcohol Use: ☐ Never ☐ Occasionally ☐ Daily

Tobacco Use: ☐ Current Smoker ☐ Never Smoked ☐ Former Smoker ☐ Occasional Smoker

How much do you smoke_____ When did you start smoking? _____ Do you chew tobacco? _____

If you quit: When did you quit? _____ How much did you smoke? _____ For how many years? _____

Illicit Drug Use: ☐ No ☐ Yes : Name of Drug _____ *When was the last time consumed*?_____

Family History

History of:

Diabetes	☐ Yes	☐ No	Aneurysms	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Bleeding Problems	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Stroke/TIA	☐ Yes	☐ No	Cancer	☐ Yes	☐ No

Other: _____

Please Provide the Names of Any Other Doctors You Are Currently Seeing:

** Referring Physician: _____

**Nephrologist (Kidney Specialist):_____Dialysis Days:_____

	Name (First, Last)	Office Address	Office Phone #
Family Physician			
Cardiologist			
Podiatrist			
Other (Specify)			
Other (Specify)			

Are you allergic to any medications, food, environmental, *iodine, shellfish, latex* or other substances? **Please specify ALLERGY & REACTIONS:_____

SAN ANTONIO VASCULAR AND ENDOVASCULAR CLINIC

Patient Name: _____ **Date:** _____

Have you ever had surgery? (*leg angiogram, stent, appendectomy etc…)*
☐ Yes ☐ No

Surgery/ Procedures	Month/Year	Hospital – City/State

Have you ever had a serious illness requiring a hospital stay other than surgery? ☐ Yes ☐ No

Reason for Hospitalization	Month/Year	Hospital – City/State

SAN ANTONIO VASCULAR AND ENDOVASCULAR CLINIC

Patient Name: _____ **Date:** _____

REVIEW OF SYSTEMS:

DO YOU HAVE NOW OR HAVE YOU HAD ANY OF THE PROBLEMS LISTED WITHIN THE LAST MONTH:

(Please circle anything for which you have a history of)

Constitutional: weight loss/gain, fatigue, Fever, loss of appetite, shakes/sweat (alcohol/drug)

Eyes: eye pain/drainage, visual changes, dry/Irritated eye

HENT: ear pain/drainage, sinus infections, hearing loss/change, nosebleeds, dizziness

Breast: masses/lumps, nipple discharge, rashes/non healing ulcers

Cardiovascular: chest pain/palpitation, heart murmur, fainting, swelling feet/legs, shortness of breath lying flat

Respiratory: blood in your sputum, wheezing, cough lasting >1 month, shortness of breath

Gastrointestinal: abdominal pain, blood in stools, nausea/vomiting, indigestion/heartburn, diarrhea, constipation, Swallowing difficulty

Genitourinary: blood in urine, menstrual changes, urinating that is painful, erection problem, vaginal discharge/bleeding

Integument/skin: rash, itching, new lesion, discharge from skin, change in skin color

Neurological: seizure, tingling or numbness, hallucinations, coughing/choking w/swallowing, excessive daytime sleepiness, extremity pain/burning

Musculoskeletal: broken bones, joint pain/swelling, muscle aches, muscular weakness, back pain

Endocrine: excessive thirst, loss of hair, increase libido, hot/cold intolerance, hot flashes

Blood-Lymph: bleeding gums/nose, unexplained bruising, night sweats, swollen painful lymph nodes

Signature of Patient/guardian (if minor) Date

SAN ANTONIO VASCULAR AND ENDOVASCULAR CLINIC

FINANCIAL POLICY

Please Read Carefully

ASSIGNMENT OF PROCEEDS

I request that payment of authorized insurance benefits be made on my behalf to San Antonio Vascular and Endovascular Clinic PLLC (The Save Clinic), for any services provided/rendered to me by the physician or supplier. I authorize any holder of medical information about me to release to my insurer and its agent to determine these benefits payable for related services.

I understand that my physician and/or staff will not release any information to my family members or me without verification of my identity in order to comply with privacy regulations. I also understand that information will be released to other healthcare professionals for the coordination of my care/treatment and/or health insurance carriers in the event that it is necessary to process a claim.

AUTHORIZATION TO RELEASE RECORDS

I hereby authorize San Antonio Vascular and Endovascular Clinic PLLC (The Save Clinic) to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

Failure to make payment in full or as stated above or failure to make other financial arrangements for payment will result in your account being placed with a collection agency. You can be charged collection and/or attorney fees which may affect your credit.

We are always available to assist you to collect from your insurance or make payments on your account balance. Your help and cooperation is necessary and appreciated.

I recognize that it is my responsibility to understand my insurance plan and keep to San Antonio Vascular and Endovascular Clinic PLLC (The Save Clinic) informed of any changes.

By my signature, I state that I have read, understand, and agree to this authorization and release.

_____

Print Name

_____ _____

Signature Date

SAN ANTONIO VASCULAR AND ENDOVASCULAR CLINIC

Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I _____ voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Patient Signature/ Personal Representative Date

_____

Printed Patient Name/ Personal Representative

SAN ANTONIO VASCULAR AND ENDOVASCULAR CLINIC

HIPAA Privacy Policy

I understand that, under the Health Insurance Policy Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (Our Notice of Privacy Practices). I understand that this information can and will used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly and to obtain payment from third-party payers. I understand that I have the right to review and receive a copy of this Notice before signing this form.
I understand that I may revoke this authorization at any time by submission in writing. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

May we leave a detailed message with another family member in your household regarding personal health information, verifying appointment times, or to change an appointment? ☐ Yes ☐ No

Name _____ Name _____

Name _____ Name _____

San Antonio Vascular and Endovascular Clinic PLLC (The Save Clinic) is hereby authorized to discuss my protected healthcare information with the individuals/providers/entities listed below:

Name _____ Phone: _____ Fax: _____

Name _____ Phone: _____ Fax: _____

Name _____ Phone: _____ Fax: _____

Information you may release subject to this signed release form follows:

☐ Complete Records	☐ History & Physical	☐ Progress Notes
☐ Lab Reports	☐ Radiology Reports	☐ Pathology Report
☐ Hospital Report	☐ Operative Report	☐ Medication list

Other: _____

By signing below, I acknowledge that I have read and understand the terms of this authorization. I hereby knowingly and voluntarily authorize San Antonio Vascular and Endovascular Clinic PLLC (The Save Clinic) to use or disclose my health information in the manner described above.

_____
Print Name

Date of Birth

_____
Witness Signature

_____
Date

SAN ANTONIO VASCULAR AND ENDOVASCULAR CLINIC

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images, and/or testimonial will be used for: Social Media, Website, and/or Advertising

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

This Authorization Is Not Required for Diagnosis or Treatment:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Patient Signature/ Personal Representative Date

Printed Patient Name/ Personal Representative Date