

PREMIER VEIN & VASCULAR

(Choice Health Care, Inc.)

1881 West Kennedy Blvd., Suite A & B, Tampa, FL 33606

3035 Lakeland Hills Blvd., Suite 4, Lakeland, FL 33805

Corp: 515 Missouri Avenue North, Largo, FL 33770

PLEASE DO NOT LEAVE ANY BLANK LINES

DATE: _____/_____/_____

HOW DID YOU HEAR ABOUT US? _____

Patient's name: _____ Birth Date: _____ Age: _____

Social Security Number: _____ Sex: M F Marital Status: S M W D

Home Address: _____
(street number/name) (city) (state) (zip)

Phone Number (home): _____ Cell Phone: _____

May we leave a detailed message on your answering machine regarding personal health information verifying appointment times, or to change an appointment? No Yes

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

May we leave a detailed message on your voice-mail either at work or on a cell phone regarding personal health information, verifying appointments times, or to change an appointment? No Yes

In case of emergency/Alternate contact/phone number: _____

Email: _____ (for access to the Patient Portal)

Occupation: _____

Employment: (circle one) FT PT SELF RETIRED NOT EMPLOYED ACTIVE MILITARY OTHER

Employer: _____ Work Phone: _____

Spouse: _____

Referring Physician: _____ Phone: _____

Family(Primary Care) Physician: _____ Phone: _____

Are you Seeing Any Specialists?
Heart? _____
Kidney? _____
Lung?Skin? _____
Neurology? _____
Podiatrist? _____
Other? _____

Are you a Dialysis Patient? Yes _____ No _____ If So,
Please list your Doctor: _____
Dialysis Center: _____
Dialysis Days: _____
Phone Number: _____

Are you a resident of a Nursing Home? Y/N Name/Phone: _____
Are you enrolled in Hospice? Y/N Under What Condition? _____

Reason for visit: _____

Pharmacy: _____ Address & Phone #: _____

INSURANCE INFORMATION *****Do you have a Health Savings or Reimbursement Account? Yes / No*****

Primary Insurance: _____

Policy #: _____ Group #: _____ Subscriber: _____

Subscriber's date of birth: _____ Subscriber's SSN: _____

Subscriber's employer: _____

Subscriber's address: _____
(street number/name) (city) (state) (zip)

Secondary Insurance: _____

Policy #: _____ Group #: _____ Subscriber: _____

Subscriber's date of birth: _____ Subscriber's SSN: _____

Subscriber's address: _____
(street number/name) (city) (state) (zip)

PLEASE HAVE YOUR INSURANCE CARDS AVAILABLE FOR PHOTOCOPYING. ALL CHARGES ARE DUE AT THE TIME OF THE SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

ATTENTION - NEW GOVERNMENT POLICY:

Our practice is now collecting new demographic data as required by The Government to aid health agencies in understanding healthcare disparities, improve quality of care, and strengthen research and outreach. We appreciate your assistance in meeting these new national standards. Premier Vein & Vascular is dedicated as your partner in improving patient care.

Preferred Language (please check one) English Spanish Other

Race (please check one) American Indian or Alaska Native Asian Black or African American Native Hawaiian or other Pacific Islander Caucasian/White Multiracial Refused/Declined

Ethnicity (please check one) Hispanic or Latino Not Hispanic or Latino Refused/Declined

Tobacco Use (please check one) Never No Yes Quit Date: _____ How many per Day? _____

Alcohol Use (please check one) Do you drink alcohol? No Yes Beer Wine Other Refused/Declined

PATIENT AUTHORIZATION, RELEASE, AND FINANCIAL RESPONSIBILITY:

I hereby authorize Choice Health Care, Inc. d.b.a Premier Vein & Vascular or its representatives to release any information acquired during my examination or treatment to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, worker's compensation carriers, adjusters or attorneys. I allow Premier Vein & Vascular to appeal any claim resulting in denial of payment on my behalf. I understand that all charges or co-payments, if applicable are due at the time of services. The patient is responsible for all fees regardless of insurance coverage, unless the services are covered under a contractual agreement between this medical practice and the patient's insurance carrier. I instruct and direct my insurance carrier(s) to pay Premier Vein & Vascular by check or electronic remittance for services billed to them on my behalf. I agree to pay any portion determined to be my responsibility including by insurance carrier including but not limited to co-payments, deductibles, and non-covered services. I assume full financial responsibility for the services not covered by insurance. I understand that Premier Vein & Vascular utilizes Physician Assistants/Nurse Practitioners for levels of practice approved by the state medical board. I understand and agree to receive services provided by such practitioners when necessary and appropriate. A photocopy of this document shall be considered as valid as the original. The undersigned certifies that he/she understands and agrees to the terms outlined above.

I authorize the release of any medical information necessary in coordination of my medical treatment/care.

Signature: _____ **Date:** _____

Relationship to Patient: _____

ACKNOWLEDGMENT

I received a copy of Choice Health Care, Inc./Rapha Vascular Specialists, Inc d.b.a. Premier Vein & Vascular's Notice of Privacy Practices.

Signature: _____ **Date:** _____

Printed Name : _____ **Date:** _____

Relationship to Patient: _____

Witness: _____ **Date:** _____

(Employee/agent of Premier Vein & Vascular)

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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

Social Security Number: _____ Sex: M / F

To Facility/Entity: _____

Phone: _____ Fax: _____

INFORMATION REQUESTED:

- ENTIRE MEDICAL RECORD
- PSYCHIATRIC RECORDS

****If only a portion of the medical record or psychiatric record is required please specify****

- Discharge Summary
- Emergency Room
- Laboratory Results
- History & Physical
- X-ray Reports
- Immunization Records
- Operative Reports
- Progress Notes
- HIV Test/Status
- Nurses Notes
- Radiology Film/Imaging CD-ROM
- Other _____

Date(s) of Service Requested:

THE ABOVE RECORD IS TO BE RELEASED TO THE FOLLOWING VIA FAX: (855) 861-0819

Choice Health Care, Inc/Rapha Vascular Specialists, Inc.

I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Signature: _____ Date: _____

Printed Name : _____ Date: _____

Relationship to Patient: _____

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PHOTOGRAPHIC IMAGE CONSENT AND RELEASE FORM

I hereby authorize Choice Health Care, Inc .d.b.a. Premier Vein & Vascular to take photographic images, and allow them to be used to help document and track the progress of my leg treatments.

I understand that these images will be the property of Premier Vein & Vascular and I will not receive compensation (either financial or otherwise) in exchange for the use of these images. I understand Premier Vein & Vascular will remove all identifying information to the best of its ability when the images will be seen by those who are not related to my care and medical treatment.

I have had the opportunity to ask questions about the purpose and manner for which the images will be used, and my questions have been answered satisfactorily. I hereby release and hold harmless Premier Vein & Vascular and their respective physicians, officers, employees and agents from liability for any claim I have, or might have, about the use these photographic images.

I understand I may refuse to sign this Authorization. If I choose not to sign, my treatment will not be affected in any way. I also understand that I may revoke the Authorization at any time except to the extent that Premier Vein & Vascular has already acted in reliance on it. I may revoke the Authorization by written notification to Jordan M Steller at Premier Vein & Vascular or current office manager.

In addition to the above stated purposes authorized, I also hereby authorize Premier Vein & Vascular to use these images for marketing and educational purposes. I understand that al od the same terms, conditions, and limitations will still apply as authorized above, and that by signing here I am allowing Premier Vein & Vascular to use the images for additional purposes and not changing the agreement in any other way. I also understand these images will have all identifying information removed when using the images for purposes of marketing and education.

Signature: _____ **Date:** _____

Printed Name : _____ **Date:** _____

Relationship to Patient: _____

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PATIENT PERSONAL HISTORY

Name: _____ Date: _____/_____/_____

Referring Physician: _____

Reason for Visit:

DRUGS AND MEDICATION:

List all medication you take, including dosage and how often (this includes home remedies, herbal supplements, birth control inhalers, non-prescriptions):

- | | |
|-----------|------------|
| 1.) _____ | 6.) _____ |
| 2.) _____ | 7.) _____ |
| 3.) _____ | 8.) _____ |
| 4.) _____ | 9.) _____ |
| 5.) _____ | 10.) _____ |

SURGERIES, HOSPITALIZATIONS AD SERIOUS ILLNESSES:

List all previous operations, hospitalizations and serious illnesses with reason and approximate dates:

- 1.) _____
- 2.) _____
- 3.) _____
- 4.) _____
- 5.) _____
- 6.) _____

IN THE PAST SIX(6) MONTHS HAVE YOU HAD:

- _____ Chest Pain/Discomfort
- _____ Palpitations (fast/irregular heart beat)
- _____ Heart Attack
- _____ Heart Valve Disease
- _____ Heart Tests? EKG, echo, stress, etc
- Where: _____
- _____ Pacemaker / Defibrillator
- _____ None of the Above

Do you have any allergies?..... No Yes

If so, to what and type of reaction?

Any anesthesia complication? No Yes

What type? _____

Any bleeding problems? No Yes

What type? _____

Have you ever had a blood transfusion? No Yes

PATIENT PERSONAL HISTORY CONT.

MEDICAL HISTORY AND PROBLEMS

Anemia..... No Yes
What Type? _____
Angina No Yes
Arthritis No Yes
Asthma No Yes
Bladder or Kidney Infection No Yes
Cancer No Yes
What Type? _____
Congestive Heart Failure No Yes
Diabetes..... No Yes
What Type? _____
Dialysis No Yes
When? _____
Where? _____
Diverticulitis..... No Yes
Emphysema No Yes
Gallbladder Disease No Yes
What Type? _____
Gastroesophageal Reflux Disease(GERD) No Yes
Heart Attack No Yes
When? _____
High Blood Pressure No Yes
Any Other Problems? _____

High Cholesterol..... No Yes
Irregular Heart Beat No Yes
What Type? _____
Kidney Failure No Yes
Kidney Stones No Yes
Liver Disease No Yes
What Type? _____
Phlebitis or blood clots..... No Yes
What body part? _____
Pneumonia or Lung Infection No Yes
Prostate Enlarged No Yes
Seizures No Yes
Stroke No Yes
When? _____
Thyroid Disease No Yes
What Type? _____
Ulcers No Yes
What Type? _____
Varicose Veins No Yes
When did symptoms start? _____
Which Leg? RIGHT / LEFT / BOTH

DO YOU NOW OR HAVE YOU EVER HAD:

Notes / Explanations

EAR, EYE, NOSE, THROAT:

Any eye disease, injury, impaired sight? No Yes _____
Any ear disease, injury, impaired hearing? No Yes _____
Any trouble with nose, sinuses, mouth, throat? No Yes _____
 No Problems now

CARDIO-RESPIRATORY:

Chronic or frequent cough? No Yes _____
Chest pain, pressure or discomfort? No Yes _____
Shortness of breath? No Yes _____
Palpitation or irregular heartbeat? No Yes _____
 No Problems now

GASTROINTESTINAL:

Trouble swallowing? No Yes _____
Nausea or vomiting? No Yes _____
Black or bloody stools? No Yes _____
Constipation or diarrhea? No Yes _____
Rectal pain, swelling or bleeding? No Yes _____
Has there been a change in
Your appetite or eating habits? No Yes _____
Your bowel habits or stools? No Yes _____

PATIENT PERSONAL HISTORY CONT.

DO YOU OR HAVE YOU EVER HAD CONT.

Notes / Explanations

Abdominal pain or swelling? No Yes _____
Weight loss? No Yes _____
Weight gain? No Yes _____
 No Problems now

GENITO-URINARY

Urinary frequency or burning? No Yes _____
Do you get up at night to urinate? No Yes _____
How many times? No Yes _____
Any difficulty in urinating? No Yes _____
 No Problems now

EXTREMITIES

Pain in leg or calf when walking? No Yes _____
Bone or joint swelling? No Yes _____
Swelling (feet or legs)? No Yes _____
Pain in legs at night? No Yes _____
Numbness (arms or legs)? No Yes _____
Weakness (arms or legs)? No Yes _____
Burning (feet or legs)? No Yes _____
Coldness (hands or feet)? No Yes _____
 No Problems now

NEUROLOGICAL

Temporary loss of vision? No Yes _____
Temporary numbness/weakness of face, arm or leg? No Yes _____
Trouble with speech? No Yes _____
Fainting or loss of consciousness? No Yes _____
Any recent development or headaches? No Yes _____
Dizziness or vertigo? No Yes _____
 No Problems now

FAMILY HISTORY

Has any blood relative ever had: WHO

Cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Do you use tobacco?..... <input type="checkbox"/> No <input type="checkbox"/> Yes
Diabetes?..... <input type="checkbox"/> No <input type="checkbox"/> Yes _____	What Type? _____
Bleeding disorder? <input type="checkbox"/> No <input type="checkbox"/> Yes _____	If yes, how much _____ day How long? _____ yrs
Vascular problems? <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Do you drink alcohol?..... <input type="checkbox"/> No <input type="checkbox"/> Yes
Heart disease? <input type="checkbox"/> No <input type="checkbox"/> Yes _____	What Type? _____
Lung problems? <input type="checkbox"/> No <input type="checkbox"/> Yes _____	If yes, how much _____ day How often? _____

Other information you feel the physicians/practitioners should know? _____

END OF PATIENT PERSONAL HISTORY.