Acct#_______________

Advanced Vein and Vascular Associates

8210 Walnut Hill Lane
Suite 408
Dallas, Texas 75231
469-547-1142

4708 Alliance Blvd.
Suite 835
Plano, Texas
469-547-1142

1105 N. Central Expressway
MOB 2, Suite 2310
Allen, Texas 75023
469-547-1142

Patient Information

Last:______________________________First:___________________________M:_____Sex:_____DOB:__________Age:_____
Address:____
Home Phone:____________________________Cell: _____________________________Work:_____________________________
Social Security #:____________________________
Employer:____Occupation:______________________________
Employer Address:____

Spouse Information
Last:______________________________First:___________________________SSN:_____________________DOB:__________
Employer:____Occupation:______________________________
Work #:____

Emergency Contact(someone who does NOT live in the house)**:**
Last:______________________________First:___________________________Relationship:____________________________
Address:____Phone #:________________________________

Insurance Information

Primary:____Phone #:________________________________
Address:____
Insured Name:____DOB:_____________________
Relationship to Patient:____
Policy #:____Group #:____________________________________
Secondary:____Phone #:_________________________________
Address:____
Insured Name:____DOB:_____________________
Relationship to Patient:____
Policy #:____Group #:____________________________________

PCP/Family Physician:____Phone #:__________________________
Referring Physician:____Phone #:__________________________

Was this injury/illness the result of an accident? ________Yes________No
Where did it occur?________Work_______Auto________Other
Date of Accident:______________________Has this been reported to your employer? ________Yes________No

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Patient Authorizations

All medical care is provided to you and not your insurance company, therefore, you are responsible for all charges. As a courtesy, we will file your medical insurance for you but we are not responsible for any limitations in coverage that may be included in your plan. The financial responsibility for all medical care is yours. We ask that you question anything you do not understand and we will be happy to answer your questions to the best of our ability. Your insurance company is the best resource for your benefits. Co-payments and deductibles are due at the time services are rendered. If you are uninsured or if the service is not covered by your carrier, you are expected to pay in full at the time of service. If you receive a payment from your insurance company in error for services rendered by AVVA, please bring it to the office or mail it to us with the Explanation of Benefits so we can post it accordingly.

Consent to Treatment
I hereby consent to an evaluation with testing and treatment as deemed necessary by my physician or his designee. ____________Initial

Assignment of Benefits/Patient Financial Responsibility
I authorize direct payment of my benefits to AVVA for services rendered to me or my dependents by my provider. I understand that this is my responsibility to know my benefits and whether or not the services I am to receive are a covered benefit. I agree to Pay any co-pay or balance due after insurance within 10 days of receiving a statement from the provider. ____________Initial

Medicare/Medicaid/Insurance Benefits
I request payment from Medicare/Medicaid or any other insurance company be made on my behalf to AVVA. I authorize release of any of my or my dependents medical records that may be requested by the carrier. I authorize any holder of medical information about me to be released to CMS, Medicaid or insurance company needed to determine benefits payable for services received. ____________Initial

X-ray, Lab or Diagnostic Services
I understand I may receive a separate bill if my medical care includes lab, x-ray or diagnostic services. I understand that I am financially responsible for any copay or balance due for these services if they are not reimbursed by my insurance for any reason. ____________Initial

PLEASE READ CAREFULLY AND SELECT APPROPRIATE RESPONSE

Authorization to release Non-public personal information and witness of HIPPA policy(in waiting room)
I certify that I have read a copy of the Patient Information Privacy Policy. I hereby authorize AVVA to release any of my or my dependents medical or incidental non-public personal information that may be necessary for evaluation, treatment, consultation, or for processing insurance benefits.
____________Initial

I do not wish my information to be disclosed to any person. ____________Initial

I give permission to disclose/discuss any information related to my medical/financial care to the following family members, other relative or close friend.

Name:____Relationship:_____________________________Phone #:____________________
Name:____Relationship:_____________________________Phone #:____________________

Authorization to call, mail or E-mail
I understand the privacy risks of the mail, phone calls and email. I hereby authorize a representative or my physician to mail, call or email me with communications regarding my healthcare, including but not limited to appointment reminders, referral arrangements and lab/x-ray results. I understand that I have the right to rescind this authorization at any time by notifying AVVA in writing. ____________Initial

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information and payment of any services not covered or approved by my carrier.

____ ____
Patient Signature or Authorized Representative Date

Patient Health History

Date:________________________________ Acct #:___________________________________

Last Name:____ First Name:___________________________________ MI:_____

Height:____ Weight:____

Please list the reason(s) for our visit to our office today:____

____

Please list all allergies including medications, shellfish, iodine, tape, latex, etc

Medication Reaction

1)____

2)____

3)____

Please list all medications that you are currently taking. This include any over-the-counter medications. (Please include any vitamins, herbs, supplements and/or appetite suppressants.) If additional space is needed we will provide an additional page for your convenience.

Medication	#Times per Day	Medication	#Times per Day
1)__________		6)__________	
2)__________		7)__________	
3)__________		8)__________	
4)__________		9)__________	
5)__________		10)__________	

Do you have any physical limitations? Yes / No Explain:____

____

Have you ever had a blood transfusion? Yes / No When?________________________________ Reaction? Yes / No

Please circle any of the following surgeries you have had and indicate date of surgery:

Surgery	Date	Surgery	Date
Tonsils	_______________	Gall Bladder	_______________
Eye Cataract	_______________	Liver	_______________
Ear	_______________	Spleen	_______________
Nose	_______________	Appendix	_______________
Cartoid (neck artery)	_______________	Arteries in leg(s)	_______________
Lung	_______________	Aneurysm	_______________
Back	_______________	Skin Cancers	_______________
Heart Bypass/Valve	_______________	Burns	_______________
Colon	_______________	Hernia	_______________

Other____

Have you ever been hospitalized for any reason besides surgery? Yes / No

Reason:____

____

____

____

Please circle any of the following medical problems you have now or have had in the past:

Measles	Mumps	Whooping Cough	Chicken Pox
Smallpox	Polio	Rheumatic Fever	Diphtheria
Rubella	Blood clot in artery	Blood clot in vein	Head injury
Emphysema	Stroke	Asthma	Wheezing
Hepatitis	Pneumonia	Blood clot in lung	Blindness
Tuberculosis	Cataracts	Kidney Failure	Heart Valve Disease
Heart Attack	Glaucoma	Kidney Stones	Diabetes
High Blood Pressure	Gallstones	Thyroid Problems	Cancer:
Coronary Artery Disease	Leg cramps	Sleep Apnea	Type________________

Angina   Shortness of Breath ________at rest________with exertion   Other______________________________

Do you wear glasses? Yes / No Reason: Reading / Near-sightedness / Far-sightedness / Other

Do any of your blood relatives (mother, father, sister, brother, child, grandparent) have any of the following conditions? (circle all that apply)

High Blood Pressure	Glaucoma	Kidney Failure	Heart Valve Disease
Heart Disease / Attack	Stroke	Tuberculosis	Diabetes
Epilepsy	Gout	Asthma	Thyroid Disease
Arthritis	Blood Disorders	Mental Disorders	

Cancer: Type____

Usual Diet____

Do you drink alcohol? Yes / No   Beer / Wine / Hard Liquor   # of 8 oz glasses per day______________________

Do you now or have you ever smoked? Yes / No   # of packs per day________________# of years_________________

When did you quit?____________________________   Cigars? Yes / No   Pipe? Yes / No

Do you use illicit drugs or abuse prescription medications? Yes / No Type__________________How Often?____________

Do you exercise? Yes / No   # of times per week_____________________# of minutes each time___________________

Number of Children____________Health status: Well / Chronic illness   Number of Deceased____________________

Parents: Mother: Living / Deceased – Age:_______________   Father: Living / Deceased – Age:_______________

Cause of death (if known):____

Number of brothers and sisters:_____________ Health status: Well / Chronic illness   Number of Deceased__________

REVIEW OF SYSTEMS

The following questions relate to health problems you have or have had in the past. Please circle the appropriate conditions.

Neurological: seizures, vertigo, previous stroke, aneurysm, hearing impairment, other

Endocrine/Hormonal: thyroid disease, adrenal disease, goiter, other

Opthamologic: glaucoma, cataracts, visual impairment, other

Ear, Nose, Throat: snoring, hearing aids, sinus, hoarseness, nose bleeds

Gastrointestinal: hiatal hernia, reflux esophagus, esophageal disease, ulcers, gastritis, duodenitis, hepatitis, yellow jaundice, other liver disease, gallstones, gallbladder disease, pancreatic disease, chronic constipation, diarrhea, diverticulitis, GI bleed, Crohn's, ulcerative colitis, irritable bowel, other intestinal issue

Renal: renal insufficiency, dialysis, kidney stones, other

Urological: prostate disease, frequent bladder infections, impotence, other

Immunological: gout, rheumatoid arthritis, lupus, other

Infectious: AIDS, hepatitis, TB, syphilis, endocarditis, other

Hematologic: anemia, bleeding problems, clotting problems, leukemia, other

Psychological: depression, anxiety, panic attacks, anorexia, bulimia, other

Physical disability: problems with walking, other

Dermatologic: psoriasis, eczema, petechiae, other

Vascular: varicose veins, aortic aneurysm

Malignancy: cancer, tumor, lymphoma

Musculoskeletal: joint pain, arthritis, weakness

Miscellaneous: osteoporosis, congenital syndrome, Marfan's Tumors

I have reviewed the above information with the patient.____(RN/PA)

Patient Health History has been reviewed by____on___________________

(Physician's signature and Date)