

PREMIER VEIN & VASCULAR

(Choice Health Care, Inc.)

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

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 voicemail either at work or on a cell phone regarding personal health information, verifying appointment 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(PrimaryCare) 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 responsibly 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. 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. d.b.a. Premier Vein & Vascular

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 all of 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.) _____ |

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? _____

PATIENT PERSONAL HISTORY CONT.

Any bleeding problems? No Yes

What type? _____

Have you ever had a blood transfusion? No Yes

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

DO YOU OR HAVE YOU EVER HAD CONT.

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 _____

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? No Yes _____

Diabetes?..... No Yes _____

Bleeding disorder? No Yes _____

Vascular problems? No Yes _____

Heart disease? No Yes _____

Lung problems? No Yes _____

Do you use tobacco?..... No Yes

What Type? _____

If yes, how much _____ day How long? _____ yrs

Do you drink alcohol?..... No Yes

What Type? _____

If yes, how much _____ day How often? _____

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

END OF PATIENT PERSONAL HISTORY.