VASCULAR & INTERVENTIONAL PARTNERS

New Patient Intake Form

Patient Information

Name: _____ DOB: _____ Sex: _____
SSN: _____ Email Address: _____
Home Phone: _____Cell Phone: _____
Address: _____
Pharmacy: _____ Crossroads: _____
Pharmacy Phone: _____ [ ] Okay to Text? [ ] Okay to Email?

Insurance Information

- Insurance Company: _____ Plan Name: _____
Policy Number: _____ Group Number: _____
- 2nd Insurance Company: _____ Plan Name: _____
Policy Number: _____ Group Number: _____
[ ] No Health Insurance / Self Pay

Physicians

- Primary Care Doctor: _____
Office Name: _____ Office Number: _____
- Specialist: _____ Specialty: _____
Office Name: _____ Office Number: _____
- Specialist: _____ Specialty: _____
Office Name: _____ Office Number: _____
- Specialist: _____ Specialty: _____
Office Name: _____ Office Number: _____

Emergency Contact

- Emergency Contact 1: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____
- Emergency Contact 2: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____
Do you have a Medical Power of Attorney? [ ] Yes [ ] No
If Yes, Name: _____ Cell Phone: _____

I authorize this office to apply benefits on my behalf for the cover services rendered. I certify that the insurance information I have provided is factual and correct.

Patient Signature: _____ Date: _____

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Health History Form (Page 1)

Name: _____ **DOB:** _____

Chief Complaint: *What are you seeking care for? (Please describe problem in detail)*

_____

_____

Medications: *Please list any medications you are taking with dose and frequency.*

Medication	Dosage / Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

[ ] See attached list of medications.

Drug Allergies: *Please list any drug allergies you have and the reactions you had.*

_____

_____

Other Allergies: *Please list any other allergies you have and the reactions you had.*

_____

_____

Previous Surgeries: *Please list past surgeries with approximate date.*

_____

_____

Do you drink alcohol? [ ] Yes [ ] No – If yes, how much/week? _____

Do you smoke? [ ] Yes [ ] No – If yes, how many cigarettes/day? _____

Do you consume caffeine? [ ] Yes [ ] No – If yes, how many cups/week? _____

Do you use recreational drugs? [ ] Yes [ ] No – If yes, what type and frequency? _____

Family History: *Do you know of any blood relative who has or had:*

[ ] Asthma [ ] Aneurysm [ ] Brain Tumor [ ] Cancer, Type: _____ [ ] Diabetes [ ] Epilepsy/Seizures

[ ] Headaches [ ] Heart Problems [ ] High Blood Pressure [ ] Kidney Disease [ ] Lung Disease [ ] Migraine

[ ] Multiple Sclerosis [ ] Psychiatric Disease [ ] Stroke [ ] Thyroid Issues [ ] No Notable Family History

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Health History Form (Page 2)

As you review the following list, please check any problems or conditions, that you are experiencing or have experienced. If you do have any of the problems listed in the section, please check none.

General Health
[ ] Good general health
[ ] Currently Pregnant
[ ] Fatigue
[ ] Fever / Chills
[ ] Loss of appetite
[ ] Recent weight change

Allergies
[ ] Adhesives
[ ] Drug allergies
[ ] Environmental allergies
[ ] Food allergies
[ ] Latex
[ ] Other: _____
[ ] None

Ears
[ ] Loss of hearing
[ ] Ringing in ears
[ ] Other: _____
[ ] None

Eyes
[ ] Blurred vision
[ ] Double vision
[ ] Glaucoma
[ ] Injury
[ ] Loss of vision
[ ] Pain
[ ] Other: _____
[ ] None

Gastrointestinal
[ ] Blood in stools
[ ] Cancer
[ ] Constipation
[ ] Nausea
[ ] Persistent diarrhea
[ ] Stomach or abdominal pain
[ ] Ulcer
[ ] Other: _____
[ ] None

Genitourinary
[ ] Blood in urine
[ ] Cancer
[ ] Female: Irregular periods
[ ] Kidney Stones
[ ] Male: Prostate disease
[ ] Male: Testicle Pain
[ ] Painful or burning urination
[ ] Renal failure
[ ] Sexual difficulty
[ ] Sexual pain
[ ] Sexually transmitted disease
[ ] Urgency with urination
[ ] Urine Incontinence
[ ] Urine retention
[ ] Other: _____
[ ] None

Heart / Cardiac
[ ] Heart attack; when? _____
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Irregular heartbeat
[ ] Pain in chest
[ ] Other: _____
[ ] None

Muscles / Joints / Bones
[ ] Back pain
[ ] Cancer
[ ] Difficulty walking
[ ] Joint pain
[ ] Joint stiffness or swelling
[ ] Muscle pain or tenderness
[ ] Neck pain
[ ] Other: _____
[ ] None

Neurological
[ ] Aneurysm
[ ] Balance trouble
[ ] Brain tumor
[ ] Black outs / Loss of consciousness
[ ] Difficulty speaking
[ ] Difficulty walking

Neurological (Con.)
[ ] Facial drooping
[ ] Headaches
[ ] Injury to brain
[ ] Injury to spine
[ ] Light-headed or dizziness
[ ] Memory loss
[ ] Mental confusion
[ ] Migraines
[ ] Mini strokes
[ ] Neuropathy
[ ] Numbness or tingling
[ ] Paralysis
[ ] Stroke
[ ] Tremors
[ ] Weakness
[ ] Other: _____
[ ] None

Psychiatric
[ ] Anxiety
[ ] Depression
[ ] PTSD
[ ] Other: _____
[ ] None

Pulmonary
[ ] Asthma
[ ] Cancer
[ ] COPD
[ ] Chronic or frequent cough
[ ] Emphysema
[ ] Pneumonia
[ ] Shortness of breath
[ ] Sleep apnea
[ ] Other: _____
[ ] None

Please use the below space to list any relevant issues not listed above.

_____
_____
_____
_____

VASCULAR & INTERVENTIONAL PARTNERS

Consent to Treat

I _____ (*Patient first and last name*) give permission for ***Vascular & Interventional Partners LLC*** to give me medical treatment. This can include but is not limited to examinations, x-rays and other types of medical imaging, photographs, anesthetics, medications, surgeries, and procedures as deemed fit by my provider.

I allow ***Vascular & Interventional Partners LLC*** to file for insurance benefits to pay for the care I receive.

I understand that:

- ***Vascular & Interventional Partners LLC*** will have to send my medical record information to my insurance company(s).
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

_____ _____

Patient Signature Date

_____ _____

Guardian Signature (If patient is under 18 or unable to sign for themselves) Date

_____

Guardian Name (Print)

VASCULAR & INTERVENTIONAL PARTNERS

Patient Agreement to Pay

Patient Name: _____ **DOB:** _____

Thank you for choosing Vascular and Interventional Partners LLC ("VIP") for your medical care. By signing this agreement, you agree to pay for all services rendered to you by VIP. Payment is due at the time services are rendered.

If you are using your health insurance, your obligation to pay may include, but is not limited to, co-insurance, deductibles, co-pays, and any other amounts not covered by your insurance. It is your responsibility to provide current and accurate insurance information, including any updates or changes to your coverage. It is your responsibility to know your insurance benefits, coverage, and exclusions. If your insurance company denies coverage or payment for services rendered to you by VIP, you assume financial responsibility and agree to pay all such charges in full.

If you do not have health insurance, or choose not to use or provide your health insurance, you agree to be solely and financially responsible for all services provided to you by VIP. As an uninsured or self-pay patient, you are entitled to a good faith estimate of the expected cost of services to be rendered.

By signing below, you certify that you have read and clearly understand your financial obligations and responsibilities. You further understand that VIP may refer your account to collections or pursue any available legal remedies in the event of non-payment.

_____ _____

Patient Signature Date

_____ _____

Guardian Signature (If patient is under 18 or unable to sign for themselves) Date

_____

Guardian Name (Print)

VASCULAR & INTERVENTIONAL PARTNERS

Authorizations for Release of Health Information

Family Members

Patient Name: _____ **DOB:** _____

Many of our patients allow family members such as their spouse, parents, or others to call or request medical or billing information. Under HIPAA guidelines, without the patient's consent we are not allowed to provide that information. If you wish to have personal information released, you must sign this form.

I _____ (Patient first and last name) authorize ***Vascular & Interventional Partners LLC*** to release my medical and billing information to the following person(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

_____ _____
Patient Signature Date

Offices Of Other Physicians You Are Seeking Care With

Your referring physician or other doctors you choose to seek care with may request your medical records for a continuation of care. Under HIPAA guidelines, we are forbidden from releasing this information without your consent. If you would like us to update your referring physician on your care with us or furnish records upon request of another physician's office, please sign below.

I _____ (Patient first and last name) authorize ***Vascular & Interventional Partners LLC*** to release my medical records to my referring physician's office and other physician's offices as requested.

_____ _____
Patient Signature Date

Authorization for Vascular & Interventional Partners to Access Outside Records

I _____ (Patient first and last name) authorize ***Vascular & Interventional Partners LLC*** to access outside lab results, medical imaging, and medical records for continuation of care.

_____ _____
Patient Signature Date