WELCOME TO VIVE VASCULAR

PATIENT DEMOGRAPHICS

Patient Name: _____

Date of Birth: _____ Email Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Address: _____

Emergency Contact Name: _____ Phone Number: _____

Race: _____ Ethnicity: _____

CARE TEAM

Primary Care Doctor: _____ Phone Number: _____

Referring Doctor: _____ Phone Number: _____

Kidney Doctor: _____ Phone Number: _____

Dialysis Unit: _____Phone Number: _____

Foot Doctor: _____ Phone Number: _____

Preferred Pharmacy: _____Phone Number: _____

INSURANCE

Primary Insurance: _____

Secondary Insurance: _____

Why are you being seen today? _____

_____

Do you have an advanced directive? Yes, copy provided Yes, copy not provided No

I hereby authorize Vive Vascular to examine and treat myself, or the patient I am signing for, and to perform such diagnostic tests and/ or x-rays or procedures as necessary for the duration of my treatment at this facility. I hereby authorize the release of any medical information necessary to process my Medicare and/ or insurance claims and for any benefits payable under my policy to be paid directly to Vive Vascular. I understand that I am responsible for payment of any charges incurred. I accept this responsibility regardless of any reimbursement of coverage. In the case of Medicare, I understand that I am responsible for payment of any charges not paid by Medicare.

Patient/Responsible Party Signature: _____ Date: _____

vive
VASCULAR

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO VIVE VASCULAR

By signing this form, I authorize you to release confidential health information about me to the physician(s), facility, or entity listed below. This includes, but is not limited to, medical records, medications, summaries or narratives of my protected health information.

Please identify the information to be released:

_____Release entire record _____Specific contents: _____

The infomation will be used for the following purpose:

_____Continuing care and treatment _____Other:_____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for drug or alcohol abuse.

I understand that once the information is released, it may be re-disclosed by the receipient and the information may not be protected by federal privacy laws or regulations.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization that I must do so in writing and present my written revocation to the practice.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The privacy of your protected health information is important to us. We have offered you a copy of our Notice of Privacy Practices. It describes how your health information will be handled and shared by our practice. By signing below, you agree that you have had a chance to review this policy and understand that these terms could change. You may obtain any revised notices by contacting Vive Vascular by phone or in writing. You also understand tat you have the right to request how your protected health information has beenn disclosed. You also have the right to restrict how this information is disclosed, however this practice may not agree to my restrictions if it would affect my care. If this practice does agree to my restrictions on PHI use, it is bound by that agreement.

PATIENT COMMUNICATION PREFERENCES

From time to time in caring for our patients, it may become necessary to contact you by telephone. If you are not available when we call, we would like to leave a detailed message when possible. There are also times where you may want us to communicate information to a trusted friend or family member. In order to protect your privacy, we need your written permission to leave such messages. This authorization will remain in affect until you recind it in writing. By signing below, you consent for Vive Vascular to leave messages on the phone number(s) listed below.

Preferred phone number for messages: _____

Name/Relationship Phone Number

Patient/Responsible Party Signature: _____ Date: _____

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MEDICAL HISTORY AND PHYSICAL

Allergies: _____

Do you Smoke? _____PPD: _____ Do you drink alcohol: _____How much?_____

CURRENT MEDICATION LIST

_____
_____
_____
_____
_____

PRIOR SURGERY / HOSPITALIZATION

_____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

Mother: _____ Deceased? Yes No
Father: _____ Deceased? Yes No
Grandparents:_____ Deceased? Yes No
Siblings: _____ Deceased? Yes No

PAST MEDICAL HISTORY (circle all that apply)

High Cholesterol	High Blood Pressure	Diabetes	Kidney Disease
Stroke / TIA	Pulmonary Embolism	PAD / Circulation	DVT / Blood Clot
CHF / CAD	Heart Attack	Heart Failure	Heart Murmur
Pacemaker	Emphysema	Sleep Apnea	Tuberculosis
Cancer	Gout	Hepatitis	Ulcers

REVIEW OF SYSTEMS (circle all that you are currently experiencing)

Fever / Chills	Leg Cramps	COPD / Emphysema	Ulcer / Wound
Weight Change	Leg Pain	Painful Urination	Rash / Itching
Blurred Vision	Leg swelling	Frequent Urination	Dizziness
Eye Pain	Skin Changes in Extremities	Blood in Urine	Weakness
Difficulty Swallowing	Coolness in Extremities	Joint Pain / Stiffness	Headaches
Mouth Ulcers	Varicose Veins	Arthritis	Balance Problems
Chest Pain	Shortness of Breath	Difficulty Walking	Anxiety
Palpitations	Asthma	Hair / Nail Changes	Depression

Other Problems: _____
_____