PATIENT INFORMATION

Today's Date: ____________________________

Patient Name: ____________________________ **Date of Birth:** ______________

(MAILING)
Address: ____
street city state zip

Home Phone: _________________ **Cell Phone:** ______________________

Please circle one:
Gender: F M **Marital Status:** M S D W

Social Security: ____/___/____ **Primary Care Physician:** __________________

HEALTH INFORMATION RELEASE FORM

Before we can discuss your medical information with anyone we must have an authorization on file. The physician and his staff have my permission to discuss and/or release my protected information to the following individuals. If you do not want to list anyone please write "No one".

NAME	RELATIONSHIP	TELEPHONE #

CONSENT TO TREAT/INSURANCE ASSIGNMENT/FINANCIAL RESPONSIBILITY

I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent of legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which may be obtained.

I authorize the office of Southeast Vascular Group (SEVG), to release any medical information required during the course of examination and treatment to my insurance company, and I permit payment to SEVG from my insurance for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.
I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay for services incurred after the patient has been charged for the office, visit, such as labs, radiology, medical supplies, etc. I agree to pay my bill in full for services rendered by SEVG.

I received a copy of the "Notice of Privacy Practices" today and agree with these privacy policies

______________________________________ ___________________________

Signature of Patient or Guardian **Date**

Patient Name: ______________________________ Date of Birth: _______________

Pharmacy Name and Phone #: ____

Drug Allergies: ____

MEDICATION LIST:

NAME/STRENGTH	DOSAGE	PRESCRIBED BY	DATE UPDATED

Patient Name: ______________________________ **Date of Birth:** _______________

PERSONAL HEALTH HISTORY:

Are you diabetic: Y N

Operations: **Illnesses: (arthritis, cancer etc)**

Type	Year	Type	Year

Pregnancies: _________ **Births:** ________

Smoke: Y N _____Packs/day **Date Quit:** _______________

Alcohol: Y N _____ drinks/week

Dialysis? (circle days) Monday Tuesday Wednesday Thursday Friday Saturday

Do you have an allergy to: (circle all that apply) Latex Betadine IV Dye

Do you have a pacemaker? Y N

Do you have any metal in body: ____

____

FAMILY HEALTH HISTORY:

Check any of the following illnesses that an immediate family member may have had:

	Auto Immune Disease		Epilepsy		Heart Disease
	Varicose Veins		Sickle Cell		Stroke
	Diabetes		Allergies		Brain hemorrhage
	Aneurysms		Asthma		High Blood Pressure

Patient Name: ______________________________ **Date of Birth:** ______________

Please check any of the following symptoms that you have experienced in the past or are currently experiencing.

	NEUROLOGICAL		EARS, EYES, NOSE & THROAT
	Fainting Spells		Nose Bleeds
	Seizures		Sinus Drainage
	Amnesia		Sore Throat
	Dizziness		Difficulty Swallowing
	Headache		Hearing Loss
	Paralysis		Vision Loss
	Vertigo		
	Fatigue		
	Weakness		
	Nervousness		
	Loss Of Strength		

	MUSCULOSKELETAL		GASTROINTESTIONAL
	Back Pain		Nausea/Vomiting
	Neck Pain		Change in Bowel Habits
	Leg Pain		Distention
	Arm Pain		Dark/Black Stool
	Fractures where?		Bloody Stool
	Joint Swelling		Hepatitis type?

	RESPIRATORY		REPRODUCTIVE & URINARY
	Shallow Breathing		Frequent Urination
	Cough		Burning on Urination
	Asthma		Blood in Urine
	Shortness of Breath		Uncontrollable bladder
			Prostate Problems

	CARDIOVASCULAR		PROSTHESIS
	Chest Pain		Dentures
	Ankle Swelling		Removable Bridge
	High Blood Pressure		Artificial Eye
	Heart Murmur		Hearing Aid
	Irregular Heart Beat		Pace Maker
	Heart Attack		Artificial Limb
	Stroke		Brace
	Blood Clot in Lung		
	Bleeding Disorder		