

We are OBSESSED with Patient Care! It all starts with getting to know you, to ensure we provide the best possible care. There is a lot here, but we know you can do it! Please fill out the information below as completely as possible. As always, if you have any questions, all of us will help (but maybe not all of us at once).

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

## Past Medical History

Please indicate if you have had any of the following by marking the corresponding check box.

### Cardiovascular

- Heart Disease
- Stroke
- Myocardial Infarction (Heart Attack)
- High Blood Pressure
- High Cholesterol
- Chest Discomfort
- Angina
- Palpitations
- Arrhythmia (skipped heart beats)
- Fluttering feeling in chest
- Atrial Fibrillation (rapid heart rate)
- Congestive Heart Failure
- Coronary Artery Disease (heart disease)
- Swelling in ankles or feet

### Ear, Nose and Throat

- Ear, nose, throat problems
- Eye Disease
- Hearing Impaired
- Allergies

### Endocrine

- Diabetes
- Thyroid Disease
- Autoimmune Disorder
- Kidney Disease

### Musculoskeletal

- Arthritis
- Osteoporosis
- Chronic Back Pain
- Joint Pain
- Muscle Weakness

### Infectious Disease

- HIV
- Hepatitis
- C-diff

### Respiratory

- Asthma
- COPD
- Shortness of Breath
- Sleep Apnea

### Neurological

- Neurological Disease
- Epilepsy
- Chronic Headaches
- Numbness and Tingling
- Alzheimer's / Dementia
- Multiple Sclerosis
- Memory Loss

### Psychiatric

- Anxiety
- Depression

### Other

- Anemia
- Bleeding Disorder
- Blood Transfusion
- Thoracic/Abdominal Aneurysm

### Vascular

- DVT
- Venous Insufficiency
- Peripheral Artery Disease

### Cancer

- Cancer (specify type below)

\_\_\_\_\_

- Cancer Treatment (specify below)

\_\_\_\_\_

## Past Surgical History

Please indicate if you have had any of the following by marking the corresponding check box.

### Cardiac Surgery

- Heart Bypass
- Heart Stents
- Pacemaker
- Cardioversion
- Mitral Valve Replacement
- Other Cardiac Surgery:  
\_\_\_\_\_

### Musculoskeletal Surgery

- Orthopedic Surgery
- Back Surgery
- Shoulder Surgery
- Foot Surgery
- Knee Surgery

### Genitourinary Surgery

- Genitourinary Surgery
- Renal Surgery
- Prostate Surgery
- Vasectomy

### \*Woman Only

- Hysterectomy
- Lumpectomy / Mastectomy

### Vascular

- Carotid Surgery
- Aneurysm Surgery
- Angioplasty/Stents
- Amputation
- Vein Ablation
- Other Vascular Surgery:  
\_\_\_\_\_

### Gastrointestinal Surgery

- Gastrointestinal Surgery
- Ulcer Surgery
- Appendectomy
- Colectomy
- Cholecystectomy
- Hernia Surgery

### Other Surgeries

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Social Use

Do you smoke cigarettes or e-cigarettes (“vape”)?  No  Yes

If so, how many packs a day or week? \_\_\_\_\_ How many cigarettes a day? \_\_\_\_\_

If applicable, at what age did you start? \_\_\_\_\_ At what age did you stop? \_\_\_\_\_

Do you drink alcohol?  No  Yes

How many drinks per day? \_\_\_\_\_

How many drinks monthly?

2 to 4 times a month: \_\_\_\_\_

3 to 4 times a week: \_\_\_\_\_

4 or more times a week: \_\_\_\_\_

Do you use recreational drugs?  No  Yes

If yes, types: \_\_\_\_\_

\_\_\_\_\_

# Family Medical History

If you have a family history of any of the following, please indicate which family member in the space provided.

## Cancer

- Colon Cancer:  
Who? \_\_\_\_\_
- Lung Cancer:  
Who? \_\_\_\_\_
- Ovarian Cancer:  
Who? \_\_\_\_\_
- Breast Cancer:  
Who? \_\_\_\_\_
- Skin Cancer:  
Who? \_\_\_\_\_
- Prostate Cancer:  
Who? \_\_\_\_\_

## Heart Disease

- Heart Disease:  
Who? \_\_\_\_\_
- Stroke:  
Who? \_\_\_\_\_
- CAD:  
Who? \_\_\_\_\_
- Hypertension:  
Who? \_\_\_\_\_
- Hyperlipidemia:  
Who? \_\_\_\_\_

## Diabetes/Renal

- Diabetes:  
Who? \_\_\_\_\_
- Renal Disease:  
Who? \_\_\_\_\_

## Respiratory

- Asthma:  
Who? \_\_\_\_\_
- Allergies:  
Who? \_\_\_\_\_
- COPD:  
Who? \_\_\_\_\_

## Psych/Social

- Psychiatric Problems:  
Who? \_\_\_\_\_
- Depression:  
Who? \_\_\_\_\_
- Substance Abuse:  
Who? \_\_\_\_\_

## Neurology

- Alzheimer's / Dementia  
Who? \_\_\_\_\_
- Neuropathy  
Who? \_\_\_\_\_

## Other

- Osteoporosis:  
Who? \_\_\_\_\_
- Anemia:  
Who? \_\_\_\_\_
- Arthritis:  
Who? \_\_\_\_\_
- Thyroid Disease:  
Who? \_\_\_\_\_

## Vascular

- Abdominal Aneurysm:  
Who? \_\_\_\_\_
- Thoracic Aneurysm:  
Who? \_\_\_\_\_

# Patient Health Checklist

Please indicate whether you have experienced any of the following...

## General

- Fever
- Chills
- Sweats
- Anorexia
- Fatigue
- Malaise
- Weight loss

## ENT

- Blurred vision
- Double vision
- Vision loss
- Cataracts
- Ear ringing
- Diminished hearing
- Sore throat

## Cardiovascular

- Chest discomfort
- Chest pains
- Palpitations
- Skipped heartbeat
- Swelling in ankles or feet
- Fluttering feeling in chest

## Respiratory

- Shortness of breath
- Chronic cough
- Asthma
- Wheezing

## Extremities

- Edema
- Open ulcers
- Gangrene
- Discolored or blue skin

## Gastrointestinal

- Indigestion
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Abdominal pain
- Ulcers
- Blood in stool

## Genitourinary

- Loss of bladder
- Blood in urine
- Burning when urinating
- Urinary frequency

## Musculoskeletal

- Arthritis
- Back pain
- Joint pain
- Muscle weakness

## Skin

- Skin rash
- Itching
- Dryness
- Lesion
- Suspicious lesions
- Ulcer

## Neurological

- Memory loss
- Seizures
- Vertigo
- Weakness
- Numbness/tingling
- Stroke

## Psychological

- Depression
- Anxiety
- Memory loss
- Unusual stress
- Mental disturbance

## Endocrine

- Cold intolerance
- Heat intolerance
- Excessive thirst
- Excessive hunger

## Hematology/Lymphatic

- Breast mass/lump
- Enlarged lymph nodes
- Unexplained bruising

## Allergy/Immunologic

- Hay fever
- Dust/pollen allergies
- Persistent infections

## Infectious Disease:

Exposed to or been recently diagnosed with... (circle one)

### ***C-diff (Clostridium difficile)***

YES NO

### ***Hepatitis***

YES NO

### ***HIV***

YES NO

### ***MRSA***

YES NO

If you circled YES for any of the above, please explain:

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## Demographic Information

Patient's Name: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Permissions:**  Home  Mobile  Work *I grant permission to have voice and/or text messages which may contain personal health information left on the phones selected.*

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Release of Records:** *I hereby authorize Vascular Centers of Texas and AVSA to disclose my medical records including information regarding my condition, treatment, imaging, and diagnosis to my emergency contact.*

Marital Status:  Single  Married  Widowed  Divorced  Separated

Occupation: \_\_\_\_\_  Employed  Retired  Student:  Full Time  Part Time

*In order for our healthcare practice to meet the qualification requirements under the American Recovery and Reinvestment Act of 2009 we are required to obtain the following information:*

1. Ethnicity  Hispanic or Latino/a  Non-Hispanic  Do not wish to respond

2. Race:  American Indian or Alaska Native  Black or African American  
 Asian  White  Other Race

Native Hawaiian or Other Pacific Island  Hispanic  Do not wish to respond

3. Language:  English  Spanish  Other: \_\_\_\_\_

## List Preferred Pharmacy

Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

## Physician Information

### Primary Care Physician

Physician Name: \_\_\_\_\_ Location: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Referring Physician

Physician Name: \_\_\_\_\_ Location: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Additional Physicians

Cardiologist: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Location: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Specialty: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Location: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Specialty: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Location: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Release of Records:**

I hereby authorize Vascular Centers of Texas and AVSA to disclose my medical records including information regarding my condition, treatment, imaging, and diagnosis to the physicians above.

## Insurance Information

**Primary Insurance:** \_\_\_\_\_

Relationship to Patient:  Self       Spouse       Parent       Other \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ Social Security#: \_\_\_\_\_

*If different from patient:*

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Relationship to Patient:  Self       Spouse       Parent       Other \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ Social Security#: \_\_\_\_\_

*If different from patient:*

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Responsible Party - Person responsible for receiving the financial statements.**

**SELF**

**Other - Please complete information below**

Name:

\_\_\_\_\_

Last	First	Middle Initial
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Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone#: \_\_\_\_\_ Secondary Phone#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email Address: \_\_\_\_\_

# AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize Vascular Centers of Texas and AVSA to release health/medical information of:

Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This information is to be released to:

Recipient: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Recipient: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Recipient: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the dates listed below. These may or may not include treatment of substance or other abuse, HIV, psychiatric disorders, sexually transmitted diseases, etc., unless herein except:

\_\_\_\_\_

This release includes all documents created by Vascular Centers of Texas and AVSA, such as but not limited to:

- Office, Chart & Progress Notes
- Ultrasound Reports
- All documents that Vascular Centers of Texas and AVSA has ordered on your behalf.

Covering records from:

- The date of its creation by Vascular Centers of Texas and AVSA, whether in the past or future.

*I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME. THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNLESS OTHERWISE REVOKED.*

Signature (person authorizing release): \_\_\_\_\_

Date of Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## Advanced Medical Directive and Power of Attorney

Do you have an Advance Medical Directive?  Yes  No (You Must Check One)

If yes, Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Do you have a Healthcare Medical Power of Attorney?  Yes  No (You Must Check One)

If yes, Name: \_\_\_\_\_

Phone: \_\_\_\_\_

## Insurance and Payments

**Financial Responsibility:** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by our specific network agreement with your insurance carrier, if such an agreement is in place.

If you do not have health insurance, or if your health insurance will not pay for services rendered by us or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Payment is due in full at the time of service.

By initialing this section, you acknowledge that you have received a copy of our Financial Policies to review.

Initial:
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A copy is available at our front desk or by request at:  
amit.sharma@vascularcentersoftexas.com

## Additional Notifications

Notice of Privacy Practice	
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By initialing this section, I acknowledge that I have received a copy of the Notice of Privacy Practice which includes a Statement of Patient's Rights to review. A copy is available at our front desk or by request at info@vascularcentersoftexas.com
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Initial:
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Code of Conduct	
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By initialing this section, I acknowledge that I have received a copy of the Code of Conduct Statement to review. A copy is available at our front desk or by request at info@vascularcentersoftexas.com
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Initial:
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Use of Media	
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By initialing this section, I acknowledge that I have received a copy of the Use of Media statement to review. A copy is available at our front desk and online or by request at info@vascularcentersoftexas.com
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Initial:
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By signing below, I voluntarily consent to all medical and surgical treatment performed by Vascular Centers of Texas and AVSA. I also consent to routine services, diagnostic procedures, medical treatment, other health care services deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent or to refuse to consent to any proposed surgery, procedure, or treatment, and to discuss it with my health care provider. I understand that if an employee or any individual associated with Vascular Centers of Texas and AVSA is exposed to my blood or bodily fluids, I will be tested for hepatitis viruses and the Human Immunodeficiency Virus (HIV).

The information on this form is accurate to the best of my knowledge.

\_\_\_\_\_  
Signature of Patient / Legally Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient / Legally Authorized Representative

\_\_\_\_\_  
Relationship to Patient