Please present your INSURANCE CARDS as well as your DRIVER'S LICENSE to be scanned into your chart.

This form must be filled out COMPLETELY.

Patient Information:

First Name:__________________ **Middle Name:**________________ **Last Name:**_________________________ Alias: __________

SS#: ________________________ **Birth Date:** _____ /______ /________ **Sex:** Male Female

Mailing Address: _____________________________________City/State: ______________________ ZIP: ________________

Home Phone: _________________________ **Cell Phone:** _____________________ **County:** ______________________

E-mail:_______________________ **Appointment reminder preference:** (**Circle one**) Text ________ or call ___________
(Number) (Number)

Other Contact Preference: e-mail phone mail

Employer: ___________________________ **Work Phone:** __________________**Your position/job title:** __________________

Race: African American Asian Hispanic White Other: ___________________________

Ethnicity: Hispanic/Latino NOT Hispanic/Latino

Patient's Marital Status: Married Divorced Separated Widowed Single

Primary Care Physician: ____________________________ **Referring Physician:** ___________________________________

How did you hear about us: ☐ **Internet Search** ☐**Facebook/Instagram** ☐**TV ad** ☐**Magazine Ad** ☐**Billboard** ☐**Referring Physician** ☐**Friend/Relative** ☐**Other:** ____

AUTHORIZATION TO RELEASE PRIVATE HEALTH INFORMATION:

I authorize the release of medical information pertaining to my health to the following individuals:

First Name:__________________ **Middle Name:**________________ **Last Name:**_________________________ **DOB:**__________

Spouse/Parent Information:

First Name:__________________ **Middle Name:**________________ **Last Name:**_________________________ Alias: __________

SS#: ________________________ **Birth Date:** _____ /______ /________ **Sex:** Male Female

Mailing Address: _____________________________________City/State: ______________________ ZIP: ________________

Home Phone: _________________________ **Cell Phone:** _____________________ **Other Phone:** ______________________

Employer: _________________ **Work Phone:** _____________________

Emergency Contact *other than spouse: **Relationship***______________________

First Name:__________________ **Middle Name:**________________ **Last Name:**_________________________ Alias: __________

Mailing Address: _____________________________________City/State: ______________________ ZIP: ________________

Home Phone: _________________________ **Cell Phone:** _____________________ **Other Phone:** ______________________

Insurance Information

Primary Insurance: __________________________ Policy Number: ___________________________Effective Date: _________
Subscriber Name: ________________________Group #______________________Phone :__________________Copay: ______

Secondary Insurance: ________________________ Policy Number: ___________________________Effective Date: _________
Subscriber Name: ________________________Group #______________________Phone :__________________Copay: ______

Additional Insurance: _________________________ Policy Number: ___________________________Effective Date: _________
Subscriber Name: ________________________Group #______________________Phone :__________________Copay: ______

I hereby grant permission to Vascular Tyler to employ such medical, surgical, and diagnostic procedures as my doctor may consider necessary in my diagnosis and treatment. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency or its intermediary, any information needed for this or a related insurance claim. I agree to pay any charges incurred by me to Vascular Tyler.

Signature: ____Date: ____________________________

______**ACKNOWLEDGEMENT OF FINANCIAL POLICY: Initials**

I have reviewed and understand this office's **Financial Policy, Assignment of Benefits**, and **Authorization to Release Information**.

______**ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES: Initial**

I have reviewed this office's **Notice of Privacy Practices**, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

______**ACKNOWLEDGEMENT OF APPOINTMENT POLICIES: Initial**

I understand that I will be charged a **$50 No-Show fee** if I confirm my appointment and then fail to show for the appointment. I also understand that I must **confirm my appointment by noon** the day prior to my appointment, or my appointment will be cancelled. I agree that my appointment will be cancelled if I am more than **15 minutes late** for my appointment.

Please contact me via phone or text (circle one) at ________________ to remind me of my appointments.

I wish to be contacted in the following manner regarding my health information (check all that apply):

Home Telephone:

__________ OK to leave message with detailed information
__________ Leave message with *call back number only*

Written Communication:

__________ OK to mail to my home address
__________ OK to mail to my work/office

Work Telephone:

__________ OK to leave message with detailed information
__________ Leave message with call back number only

____

Signature of patient or personal representative   Date

____

Printed name of patient or personal representative

Patient Name: **Date of birth:**

Referring doctor (new visits only):

____

Reason for Visit:

____

HISTORY

Please circle all that apply. When you cannot find your diagnosis or surgery in the list, feel free to write it in under the appropriate system or anywhere on the page if unsure.

Past Medical History

- **I have no significant medical history.**

Neurologic:

- Alzheimer's, brain tumor, cerebral AVM, cerebral artery aneurysm, dementia, headache syndrome, hemiplegia, migraine headaches, multiple sclerosis, neuropathy, Parkinson's disease, restless leg syndrome, seizure disorder, stroke syndrome, transient ischemic attack/TIA, traumatic brain injury, other_________________________________

Head, Eyes, Ears, Throat:

- Cataract, deafness, glaucoma, hearing loss, blindness, other______________________________

Cardiovascular:

- Aortic aneurysm/AAA, iliac aneurysm, thoracic aortic aneurysm/TAA, other arterial aneurysm, aneurysm of vein, atrial fibrillation, carotid artery stenosis, congestive heart failure/CHF, coronary artery disease, DVT, hyperlipidemia, hypertension, lymphedema, murmur, heart attack/MI, peripheral artery disease, pulmonary embolism, valvular heart disease, varicose veins, venous insufficiency, other_______________________________________

Respiratory:

- Asthma, COPD, oxygen dependent, sleep apnea, other_______________________________________

Gastrointestinal/Abdominal:

- Celiac disease, cirrhosis, Crohn's disease, diverticulitis, esophageal reflux/GERD, gallbladder disease, hepatitis, irritable bowel syndrome/IBS, mesenteric artery stenosis, other_______________________________________

Renal/Kidney:

- Chronic renal failure, ESRD/dialysis, nephrosclerosis, renal artery stenosis, other____________________

Urologic/Gynecologic:

- Prostate hypertrophy, chronic urinary tract infection, other urologic/ gynecologic diagnosis____________________________________

Musculoskeletal/Orthopedic:

- Amputation: _________________________________, chronic pain syndrome, gout, degenerative disc disease, low back pain, osteoarthritis, osteoporosis, other_______________________________________

Dermatologic/skin:

- Dermatitis, other_____________________________

Endocrine:

- Hyperthyroidism, hypothyroidism, thyroid nodule, type 1 diabetes, type 2 diabetes, obesity, other________________________________

Rheumatologic:

- Rheumatoid arthritis, Sjogren's syndrome, lupus, other____

Infectious disease:

- AIDS, HIV, Lyme disease, other_________________

Hematologic/Blood disorders:

- Anemia, thrombocytopenia, bleeding disorder, other ______________________________________

Oncologic/Cancer:

- Breast cancer, colon cancer, kidney cancer, lung cancer, skin cancer, prostate cancer, other ______________________________________

Psychiatric:

- Alcoholism, anxiety disorder, ADHD, bipolar disorder, depression, schizophrenia, other______________________________________

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Past Surgical History

- **I have no significant surgical history.**

I experienced a reaction to general anesthesia

Carotid Surgery:

- Carotid angiogram, carotid bypass surgery, carotid endarterectomy, vertebral artery angiogram, other____

Arterial intervention of the leg:

- Angiogram of the right leg, angiogram of the left leg, bypass surgery of the right leg, bypass surgery of the left leg, other___________________________

Other arterial procedures:

- Arterial embolectomy/thrombectomy, endovascular repair of aortic aneurysm/EVAR, open repair of aortic aneurysm, renal artery angiogram, mesenteric/celiac artery angiogram, other____

Venous procedures/treatments:

- Venous intervention/treatment of the right leg, venous intervention/treatment of the left leg, cosmetic sclerotherapy, venous thrombectomy, venogram, other______________________________

Dialysis access/maintenance:

- AV fistula, AV graft, peritoneal dialysis/PD catheter, fistulogram with intervention, revision of fistula/graft, thrombectomy of fistula/graft, fistula aneurysm repair, other________________________

Cardiac:

- Heart catheter, defibrillator, heart bypass/CABG, heart stent, pacemaker, other__________________

Pulmonary:

- Pneumonectomy, other_______________________

Gastrointestinal/Abdominal:

- Appendectomy, cholecystectomy. Gallbladder, colostomy, gastric bypass/banding, hernia repair, colectomy, other_____________________________

Head, Eyes, Ears, Throat:

- Cataract, partial thyroidectomy, total thyroidectomy, parathyroid surgery, tonsillectomy, other ______________________________________

Neurosurgery:

- Brain surgery, vagal nerve stimulator placement, other____

Orthopedic:

- Amputation, carpal tunnel syndrome, hip replacement, knee replacement, other knee surgery, low back surgery, rotator cuff repair, shoulder surgery, spinal surgery, other____

Urologic/Gynecologic Surgery:

- Bladder surgery, C-section, D&C, hysterectomy, nephrectomy/kidney removal, atherectomy/ovary removal, prostatectomy, tubal ligation, mastectomy, other urologic/ gynecologic surgery____________________________________

Breast surgery:

- Breast biopsy, lumpectomy, mastectomy, other______________________________________

Oncologic treatment:

- Radiation therapy, other ______________________

Cosmetic surgery:

- Abdominoplasty/tummy tuck, breast reduction, breast augmentation, other______________________________________

FAMILY HISTORY

Circle all that apply

1. No family history
2. Adopted
3. Stroke
4. Carotid artery stenosis
5. Peripheral artery disease
6. Venous disease/varicosities
7. DVT
8. Pulmonary embolism
9. Abdominal aortic aneurysm
10. Other arterial aneurysm
11. Coronary artery disease/heart attack
12. Congestive heart failure
13. Hypertension
14. Hyperlipidemia
15. Other heart disease
16. Diabetes mellitus
17. Pulmonary disease
18. Renal disease
19. Gastrointestinal disease
20. Autoimmune disease
21. Blood disorders
22. Cancer

Other family history____

OTHER MEDICAL HISTORY

1. Do you use nicotine products: Yes No
   a. smoke
   b. vape
   c. use smokeless tobacco
2. Do you drink alcohol? Yes No
3. Do you use recreational drugs?
4. Do you exercise?
5. Do you
   a. Live alone
   b. Live with a spouse
   c. Live in a skilled nursing facility or rehab?
   d. Other: _________________________
6. Do you require dialysis? Yes No
   a. Peritoneal dialysis
   b. Hemodialysis

   Dialysis center: ________________________________

   Mon-Wed-Fri OR Tue-Thurs-Sat
7. Have you served in the Military? Yes No
   a. Which Branch:
8. Work History
   a. Occupation
   b. Retired
   c. Disable

CURRENT MEDICATIONS

ALLERGIES: Please put reaction in parenthesis next to the drug, food, or environmental trigger.
Example: penicillin (rash), aspirin (wheezing)

Drug:____

Food:____

Environmental:____

CURRENT MEDICATIONS	DOSE (MG)	HOW OFTEN