Patient Information

Last Name:	First Name:	Middle Initial:	
Address:	City:	State:	Zip Code:
Date of Birth (MM/DD/YY):			
Sex: Male Female	Marital Status: Single	Married	Divorced Widowed
Home Phone #:	Mobile Phone #:		
Email Address:			
In Case of Emergency Please Contact: Name:	Relationship to Patient: Phone #:		

Employer Information

Employer Name:	Employment Status: ☐ Full Time ☐ Student	☐ Part Time ☐ Retired	
Address:	City:	State:	Zip Code:
Work Phone Number:	Patient Occupation:		

Insurance Information (Please provide card to Front Office)

Primary Insurance Plan Name:			
Insured Name:	Date of Birth:		
Insured Employer:	Employer Phone Number:		
Secondary Insurance Plan Name:			
Insured Name:	Date of Birth:		
Insured Employer:	Employer Phone Number:		

Physician Information

Name of Referring Physician:	Name of Primary Physician:	
How did you find our practice? (circle all that apply)	Website/Internet	Referral

Do you have a Preferred Pharmacy? ☐ Yes ☐ No If yes, please provide the following information:

Name of Pharmacy:	Phone Number:	
City:	State:	Zip Code:

TEXAN VEIN & VASCULAR

Vascular Surgery Clinic

Name: _____ Date: _____

Date of Birth: _____ Height: _____ Weight: _____

MEDICATIONS (Prescription, Over the counter and Vitamins)

MEDICATION	DOSE	FREQUENCY

MEDICATION ALLERGY NONE ☐

NAME OF MEDICATION	REACTION

Vascular Surgery Clinic

MEDICAL HISTORY

Please circle "YES" or "NO" to any past or current medical conditions

YES	NO	Atrial Fibrillation / Arrhythmia
YES	NO	Coronary Arterial Disease
YES	NO	Heart Failure
YES	NO	Dementia
YES	NO	Seizure Disorder
YES	NO	Diabetes Mellitus Type 2
YES	NO	Asthma
YES	NO	Chronic Obstructive Pulmonary Disease/Emphysema
YES	NO	Bleeding Disorder
YES	NO	Anemia
YES	NO	Deep Vein Thrombosis
YES	NO	Pulmonary Embolism
YES	NO	HIV
YES	NO	High Cholesterol / Hyperlipidemia
YES	NO	Myocardial Infarction / Heart Attack
YES	NO	Depression
YES	NO	Drug Abuse
YES	NO	Hepatitis C
YES	NO	Peptic Ulcer Disorder
YES	NO	Chronic Kidney Disease / End Stage Renal Disease
YES	NO	Stroke / TIA
YES	NO	Obstructive Sleep Apnea
YES	NO	Liver Cirrhosis
YES	NO	Hypertension

Vascular Surgery Clinic

SURGICAL HISTORY

		DATE
YES	NO	
YES	NO	
YES	NO	
YES	NO	
YES	NO	
Please List Other Surgery(ies):		

CABG (Coronary Bypass Graft)
PTCA Hx (Coronary Angioplasty)or Stent
Angioplasty / Leg Stent/Leg Bypass
Varicose Vein Surgery
Other

FAMILY HISTORY

Relationship	Heart Disease	Stroke	Aneurysm	Other Vascular Problems (Please Specify)	Varicsoe Veins
Mother					
Father					
Sister					
Brother					
Grandmother					
Grandfather					

Vascular Surgery Clinic

SOCIAL HISTORY

YES	NO	NEVER	
			Do you smoke?
			Number of years
			Packs per day
	YES	NO	Interested in quitting?
			Number of years prior to quiting

YES	NO	NEVER	
DAILY	WEEKLY	MONTHLY	How often?
WINE	BEER	OTHER	Which alcoholic beverage?
	YES	NO	Drug abuse?

CHIEF COMPLAINT/REASON FOR VISIT TODAY (PLEASE SPECIFY)

Patient Name

Date

FINANCIAL POLICY

As we enter the doctor-patient relationship, we agree to provide quality healthcare at a fair and reasonable price, and you in turn, agree it is your obligation to understand your insurance benefits and be prepared to pay at the time of service. This is an explanation of our financial policy, so there are no unpleasant surprises.

Please Initial Each Section

___ **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, MasterCard, Visa, American Express, Discover and Care Credit. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due prior to these services being provided. Any remaining balance after your health plans pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will note as "Self-Pay" and payment will be due in full. Account balance over 90 days with no payment activity will be reported to the credit bureau(s).

___ **Your insurance policy is a contract between you and your insurer. It is your responsibility to know what your policy covers and what It does not although we will help you get the most out of your benefits.** When your coverage is verified by our office personal, we are given a disclaimer informing it is only a quote of benefits and not a guarantee of payment. Payment is determined once the claim is received and processed by your insurer. **Any item deemed "Non-Covered" will be your financial responsibility.** We do not accept 'Usual and Customary' payments. Any disputes about payment must be resolved between you and your insurer. You are responsible for ensuring a properly dated referral and/or authorization if required by your insurer for services being provided. It is your responsibility to make certain you have subsequent authorizations during ongoing treatment. You are also responsible for payment if your claim denies for lack of referral/authorizations.

___ **As a courtesy to you, we will file primary participating insurance for you with proper assignment.** Insurance will not be accepted if presented after 3 business days from the date of your appointment. Any additional policies will be yours to file with your receipt from our office. Please bring your insurance card(s) with you to every and provide the front desk with any updated information at the time of check-in. All remaining balances are your responsibility to satisfy prior to additional services being rendered.

___ This office is not party to legal disputes or agreements. The financial responsibility rest with the patient.

___ If you are 15 minutes late, your appointment will need to be rescheduled. You will be responsible for the missed appointment fee of $85.00. No Show/Late fees will be applied for appointments that are not cancelled 24 hours PRIOR to the appointment. New patient paperwork that is not completed by the appointment time will result in a missed appointment fee and the appointment will need to be rescheduled.

___ Payments & credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding date(s) of service.

ASSIGNMENT AND AUTHORIZATION OF BENEFITS

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and other plans to Texan Vein and Vascular. I understand that I am responsible for all charges, obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

_____

Responsible Party **Date**

TEXAN VEIN AND VASCULAR COMMUNICATION

Do we have permission to: Please circle Y(YES) or N(NO)

Y/N ACQUIRE IMAGES/PHOTOS OF VEINS FOR MEDICAL RECORD PURPOSES? (Photos are confidential as part of the medical record)

Y/N LEAVE A VOICEMAIL ON PHONE NUMBER PROVIDED?

Y/N LEAVE A MESSAGE AT WORK?

Y/N DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF OUR HOUSEHOLD? IF SO:

Person: _____ **Relationship:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

_____

Print Name Patient Signature Date