PREMIER VEIN & VASCULAR

(Choice Health Care, Inc.)
1881 West Kennedy Blvd., Suite A & B, Tampa, FL 33606
Corp: 515 Missouri Avenue North, Largo, FL 33770

PLEASE DO NOT LEAVE ANY BLANK LINES **DATE: _____/ _____/_____**

HOW DID YOU HEAR ABOUT US? _____

Patient's name: _____Birth Date: _____ Age: _____

Social Security Number: _____ Sex: M F Marital Status: S M W D

Home Address: _____
(street number/name) (city) (state) (zip)

Phone Number (home): _____Cell Phone: _____

May we leave a detailed message on your answering machine regarding personal health information verifying appointment times, or to change an appointment? No Yes

May we leave a detailed message with another family member in your household regarding personal health information, verifying appointments, or to change an appointment? No Yes

May we leave a detailed message on your voicemail either at work or on a cell phone regarding personal health information, verifying appointments times, or to change an appointment? No Yes

In case of emergency/Alternate contact/phone number: _____

Email: _____ (for access to the Patient Portal)

Occupation: _____

Employment: (circle one) FT PT SELF RETIRED NOT EMPLOYED ACTIVE MILITARY OTHER

Employer: _____ Work Phone: _____

Spouse: _____

Referring Physician: _____Phone:_____

Family(PrimaryCare) Physician: _____Phone: _____

Are you Seeing Any Specialists?

Heart?_____

Kidney? _____

Lung?Skin?_____

Neurology?_____

Podiatrist?_____

Other?_____

Are you a Dialysis Patient? Yes_____No_____ If So,

Please list your Doctor:

_____

Dialysis Center:

_____

Dialysis Days: _____

Phone Number:_____

Are you a resident of a Nursing Home? Y/N **Name/Phone:** _____

Are you enrolled in Hospice? Y/N **Under What Condition?** _____

Reason for visit: _____

Pharmacy: _____ _____**Address & Phone #:**_____

INSURANCE INFORMATION ******Do you have a Health Savings or Reimbursement Account? Yes / No*******

Primary Insurance: _____

Policy #:_____ **Group #:**_____ **Subscriber:** _____

Subscriber's date of birth: _____ **Subscriber's SSN:**_____

Subscriber's employer: _____

Subscriber's address: _____

(street number/name) **(city)** **(state)** **(zip)**

Secondary Insurance: _____

Policy #:_____ **Group #:**_____ **Subscriber:** _____

Subscriber's date of birth: _____ **Subscriber's SSN:** _____

Subscriber's address: _____

(street number/name) **(city)** **(state)** **(zip)**

PLEASE HAVE YOUR INSURANCE CARDS AVAILABLE FOR PHOTOCOPYING. ALL CHARGES ARE DUE AT THE TIME OF THE SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

ATTENTION - NEW GOVERNMENT POLICY:
Our practice is now collecting new demographic data as required by The Government to aid health agencies in understanding healthcare disparities, improve quality of care, and strengthen research and outreach. We appreciate your assistance in meeting these new national standards. Premier Vein & Vascular is dedicated as your partner in improving patient care.

Preferred Language (please check one) □ English □ Spanish □ Other

Race (please check one) □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ Caucasian/White □ Multiracial □ Refused/Declined

Ethnicity (please check one) □ Hispanic or Latino □ Not Hispanic or Latino □ Refused/Declined

Tobacco Use(please check one) □ Never □ No □ Yes Quit Date: _____ How many per Day? _____

Alcohol Use (please check one) Do you drink alcohol? □ No □ Yes □ Beer □ Wine □ Other □ Refused/Declined

PATIENT AUTHORIZATION, RELEASE, AND FINANCIAL RESPONSIBILITY:

I hereby authorize Choice Health Care, Inc. d.b.a Premier Vein & Vascular or its representatives to release any information acquired during my examination or treatment to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, worker's compensation carriers, adjusters or attorneys**. I allow Premier Vein & Vascular to appeal any claim resulting in denial of payment on my behalf. I understand that all charges or co-payments, if applicable are due at the time of services**. The patient is responsible for all fees regardless of insurance coverage, unless the services are covered under a contractual agreement between this medical practice and the patient's insurance carrier. I instruct and direct my insurance carrier(s) to pay Premier Vein & Vascular by check or electronic remittance for services billed to them on my behalf. I agree to pay any portion determined to be my responsibly including by insurance carrier including but not limited to co-payments, deductibles, and non-covered services. I assume full financial responsibility for the services not covered by insurance. I understand that Premier Vein & Vascular utilizes Physician Assistants/Nurse Practitioners for levels of practice approved by the state medical board. I understand and agree to receive services provided by such practitioners when necessary and appropriate. A photocopy of this document shall be considered as valid as the original. The undersigned certifies that he/she understands and agrees to the terms outlined above.

I authorize the release of any medical information necessary in coordination of my medical treatment/care.

Signature: _____ Date: _____

Relationship to Patient: _____

ACKNOWLEDGMENT

I received a copy of Choice Health Care, Inc. d.b.a. Premier Vein & Vascular's Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name : _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____
(Employee/agent of Premier Vein & Vascular)

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____Birth Date: _____ Age: _____

Social Security Number: _____ Sex: M / F

To Facility/Entity:_____

Phone:_____ Fax:_____

INFORMATION REQUESTED:

- ENTIRE MEDICAL RECORD
- PSYCHIATRIC RECORDS

****If only a portion of the medical record or psychiatric record is required please specify****

- Discharge Summary
- Emergency Room
- Laboratory Results
- History & Physical
- X-ray Reports
- Immunization Records
- Operative Reports
- Progress Notes
- HIV Test/Status
- Nurses Notes
- Radiology Film/Imaging CD-ROM
- Other_____

Date(s) of Service Requested:

THE ABOVE RECORD IS TO BE RELEASED TO THE FOLLOWING VIA FAX: (855) 861-0819

Choice Health Care, Inc. d.b.a. Premier Vein & Vascular

I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that id the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described about may be re-disclosed and no longer protected by these regulations I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Signature: _____ Date: _____

Printed Name: _____ Date: _____

Relationship to Patient: _____

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PHOTOGRAPHIC IMAGE CONSENT AND RELEASE FORM

I hereby authorize Choice Health Care, Inc .d.b.a. Premier Vein & Vascular to take photographic images, and allow them to be used to help document and track the progress of my leg treatments.

I understand that these images will be the property of Premier Vein &Vascular and I will not receive compensation (either financial or otherwise) in exchange for the use of these images. I understand Premier Vein & Vascular will remove all identifying information to the best of its ability when the images will be seen by those who are not related to my care and medical treatment.

I have had the opportunity to ask questions about the purpose and manner for which the images will be used, and my questions have been answered satisfactorily. I hereby release and hold harmless Premier Vein & Vascular and their respective physicians, officers, employees and agents from liability for any claim I have, or might have, about the use these photographic images.

I understand I may refuse to sign this Authorization. If I choose not to sign, my treatment will not be affected in any way. I also understand that I may revoke the Authorization at any time except to the extent that Premier Vein & Vascular has already acted in reliance on it. I may revoke the Authorization by written notification to Jordan M Steller at Premier Vein & Vascular or current office manager.

In addition to the above stated purposes authorized, I also hereby authorize Premier Vein & Vascular to use these images for marketing and educational purposes. I understand that al od the same terms, conditions, and limitations will still apply as authorized above, and that by signing here I am allowing Premier Vein & Vascular to use the images for additional purposes and not changing the agreement in any other way. I also understand these images will have all identifying information removed when using the images for purposes of marketing and education.

Signature: _____ Date: _____

Printed Name : _____ Date: _____

Relationship to Patient: _____

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PATIENT PERSONAL HISTORY

Name: _____ **Date:**_____/ _____/ _____

Referring Physician: _____

Reason for Visit:

DRUGS AND MEDICATION:
List all medication you take, including dosage and how often(this includes home remedies, herbal supplements, birth control inhalers, non-prescriptions):

1.) _____ 6.) _____
2.) _____ 7.) _____
3.) _____ 8.) _____
4.) _____ 9.) _____

SURGERIES, HOSPITALIZATIONS AD SERIOUS ILLNESSES:
List all previous operations, hospitalizations and serious illnesses with reason and approximate dates:

1.) _____
2.) _____
3.) _____
4.) _____
5.) _____
6.) _____

IN THE PAST SIX(6) MONTHS HAVE YOU HAD:

_____Chest Pain/Discomfort
_____Palpitations (fast/irregular heart beat)
_____ Heart Attack
_____ Heart Valve Disease
_____Heart Tests? EKG, echo, stress, etc
Where: _____
Pacemaker / Defibrillator
_____None of the Above

Do you have any allergies?.....□ No □ Yes

If so, to what and type of reaction?

Any anesthesia complication? .....□ No □ Yes
What type? _____

PATIENT PERSONAL HISTORY CONT.

Any bleeding problems? .....□ No □ Yes
What type? _____
Have you ever had a blood transfusion? .....□ No □ Yes

MEDICAL HISTORY AND PROBLEMS

Anemia.....□ No □ Yes
What Type? _____
Angina .....□ No □ Yes
Arthritis .....□ No □ Yes
Asthma .....□ No □ Yes
Bladder or Kidney Infection .....□ No □ Yes
Cancer .....□ No □ Yes
What Type? _____
Congestive Heart Failure .....□ No □ Yes
Diabetes.....□ No □ Yes
What Type? _____
Dialysis .....□ No □ Yes
When? _____
Where? _____
Diverticulitis.....□ No □ Yes
Emphysema .....□ No □ Yes
Gallbladder Disease .....□ No □ Yes
What Type? _____
Gastroesophageal Reflux Disease(GERD) .....□ No □ Yes
Heart Attack .....□ No □ Yes
When? _____
High Blood Pressure .....□ No □ Yes
High Cholesterol.....□ No □ Yes
Irregular Heart Beat .....□ No □ Yes
What Type? _____
Kidney Failure .....□ No □ Yes
Kidney Stones .....□ No □ Yes
Liver Disease .....□ No □ Yes
What Type? _____
Phlebitis or blood clots.....□ No □ Yes
What body part? _____
Pneumonia or Lung Infection .....□ No □ Yes
Prostate Enlarged .....□ No □ Yes
Seizures .....□ No □ Yes
Stroke .....□ No □ Yes
When? _____
Thyroid Disease .....□ No □ Yes
What Type? _____
Ulcers .....□ No □ Yes
What Type? _____
Varicose Veins .....□ No □ Yes
When did symptoms start? _____
Which Leg? RIGHT / LEFT / BOTH
Any Other Problems? _____

DO YOU NOW OR HAVE YOU EVER HAD: **Notes / Explanations**

EAR, EYE, NOSE, THROAT:
Any eye disease, injury, impaired sight? .....□ No □ Yes _____
Any ear disease, injury, impaired hearing? .....□ No □ Yes _____
Any trouble with nose, sinuses, mouth, throat? .....□ No □ Yes _____
□ No Problems now

CARDIO-RESPIRATORY:
Chronic or frequent cough? .....□ No □ Yes _____
Chest pain, pressure or discomfort? .....□ No □ Yes _____
Shortness of breath? .....□ No □ Yes _____
Palpitation or irregular heartbeat? .....□ No □ Yes _____
□ No Problems now

GASTROINTESTINAL:
Trouble swallowing? .....□ No □ Yes _____
Nausea or vomiting? .....□ No □ Yes _____
Black or bloody stools? .....□ No □ Yes _____
Constipation or diarrhea? .....□ No □ Yes _____

DO YOU OR HAVE YOU EVER HAD CONT.

Notes / Explanations

Rectal pain, swelling or bleeding? .....□ No □ Yes _____

Has there been a change in

Your appetite or eating habits? .....□ No □ Yes_____

Your bowel habits or stools? .....□ No □ Yes _____

Abdominal pain or swelling? .....□ No □ Yes_____

Weight loss? .....□ No □ Yes _____

Weight gain? .....□ No □ Yes_____

□ No Problems now

GENITO-URINARY

Urinary frequency or burning? .....□ No □ Yes _____

Do you get up at night to urinate? .....□ No □ Yes _____

How many times? .....□ No □ Yes _____

Any difficulty in urinating? .....□ No □ Yes _____

□ No Problems now

EXTREMITIES

Pain in leg or calf when walking? .....□ No □ Yes _____

Bone or joint swelling? .....□ No □ Yes _____

Swelling (feet or legs)? .....□ No □ Yes _____

Pain in legs at night? .....□ No □ Yes_____

Numbness (arms or legs)? .....□ No □ Yes _____

Weakness (arms or legs)? .....□ No □ Yes_____

Burning (feet or legs)? .....□ No □ Yes _____

Coldness (hands or feet)? .....□ No □ Yes_____

□ No Problems now

NEUROLOGICAL

Temporary loss of vision? .....□ No □ Yes_____

Temporary numbness/weakness of face, arm or leg? □ No □ Yes _____

Trouble with speech? .....□ No □ Yes _____

Fainting or loss of consciousness? .....□ No □ Yes_____

Any recent development or headaches? .....□ No □ Yes_____

Dizziness or vertigo? .....□ No □ Yes_____

□ No Problems now

FAMILY HISTORY

Has any blood relative ever had: WHO

Cancer? .....□ No □ Yes _____

Diabetes?.....□ No □ Yes _____

Bleeding disorder? .....□ No □ Yes _____

Vascular problems? .....□ No □ Yes _____

Heart disease? .....□ No □ Yes _____

Lung problems? .....□ No □ Yes _____

Do you use tobacco?.....□ No □ Yes

What Type? _____

If yes, how much _____day How long? _____yrs

Do you drink alcohol?.....□ No □ Yes

What Type? _____

If yes, how much _____day How often? _____

Other information you feel the physicians/practitioners should know? _____

_____

END OF PATIENT PERSONAL HISTORY.