R N **San Fernando Valley Vascular Group**

TZ WH BURB VAL Patient Information

Personal Information

Date: _____/_____/_____

Last Name: _____ First Name: _____ Middle Initial: _____ □Mr. □Mrs. □Ms. □Dr.

Marital Status: □ Married □Single □ Divorced □ Widowed

Date of Birth: _____/_____/_____ Age: _____ Sex: □ Male □ Female

Social Security: _____ - _____ - _____ Email Address: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Nursing Home _____ Phone: (_____) _____ - _____

Spouse/ Child Name: _____ Phone: (_____) _____ - _____

Race: _____ Ethnicity: _____ Language: _____

Pharmacy: Name: _____ City: _____ Phone #:_____

Phvsicians who care for vou

Referring Physician: _____ Primary Care Physician: _____

Cardiologist: _____ Nephrologists: _____

Dialysis Unit: _____ Tel: _____ Dialysis Days: □M □T □W □Th □ F □S

Insurance Information

Primary Insurance: _____ I.D. Number: _____

Name of Insured: _____ Date of Birth: _____/_____/_____

Relationship to Insured: _____ Group #: _____

Secondary Insurance: _____ I.D. Number: _____

Name of Insured: _____ Date of Birth: _____/_____/_____

Relationship to Insured: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

I do hereby consent to and authorize the performance of all treatments, surgery, and all medical services by San Fernando Valley Vascular Group. I accept full financial responsibility for all medical/surgical services performed on my behalf if not covered by my insurance company.

All co-payments, deductibles and non-covered services are due at the time of service.

I do hereby authorize provider to release all information necessary acquired in the course of my examination and/or treatment to secure payment for services.

I do authorize my insurance company to pay benefit directly to San Fernando Valley Vascular Group.

X_____ _____

Patient or Guardian's Signature Date

San Fernando Valley Vascular Group

Phone (818)345-6126 Fax (818)345-5061

HISTORY

Name:	Date of Birth:	Date:

Age: _____ **Sex:** □ M □ F **Referring M.D.**: _____

What is the reason of your visit today: _____

Allergies: None Reaction_____

Ambulation: □ walking □ with cane/walker □ wheel chair □ stretcher □ Nursing home

Social History:

Smoking: □ Never

□ Current: __ Light (1-9 cig/day) __ Moderate (10-19 cig/day) __ Heavy (20-39 cig/day)

□ Former: When was the last time you smoked: _____

How much did you smoke: __Light (1-9 cig/day) __Moderate (10-19 cig/day) __ Heavy (20-39 cig/day)?

Alcohol: □ Never

□ Current □ Monthly □ 2-4 x/mo. □ 2-3 x/week □ 4 or more / week

□ 1-2 drinks □ 3-4 drinks □ 5-6 drinks □ 7-9 drinks □ more than 10 drinks

Exercise □ No □ Yes _____x/wk.

Surgical History: (list operations and dates)

_____

_____

_____

_____

_____

Medical History:

_____

_____

_____

_____

_____

Medications	**Dose**	**Frequency**	**Medications**	**Dose**	**Frequency**

Family History: Mother: □ Alive □ Deceased Father: □ Alive □ Deceased

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BP: _____mmHg P: _____B/min Ht: _____ Wt: _____Lbs.

San Fernando Valley Vascular Group
REVIEW OF SYSTEM

Name:

Date:

Vascular: Please check all that applies

	RIGHT			LEFT		
	Leg	Arm	Foot	Leg	Arm	Foot
Pain						
Swelling						
Numbness						
Tingling						
Change in Skin Color						
Ulcers						
Infection						
Gangrene						

☐ Varicose Veins ☐ Vein Stripping
☐ Blood Clots ☐ IVC Filter ____yr.
☐ Angioplasty _____yr.
☐ Leg Bypass Surgery_____yr.
☐ Neck Artery (carotid) Surgery Rt Lt _____yr.
☐ Amputation: Above Knee - Rt - Lt
Below Knee - Rt - Lt
☐ History of Aneurysm Surgery _____yr.

Renal:

☐ Blood in Urine ☐ Discharge ☐ Frequency ☐ Nocturia ☐ Pain upon Urination
☐ Impotence ☐ Renal Failure ☐ Dialysis Days: Mon Tues Wed Thurs Friday Sat Sun
☐ Dialysis Unit Name _____ ☐ Phone number_____

Respiratory/Lungs:

☐ Cough ☐ Sputum ☐ Blood in Sputum ☐ Shortness of Breath ☐ Asthma ☐ Tuberculosis
☐ Sleep Apnea ☐ Emphysema ☐ COPD - Not Treated - On Medication - On Oxygen

Cardiac:

☐ Chest Pain/Tightness ☐ Palpitation ☐ High Blood Pressure ☐ Heart Murmur ☐ Heart Attack
☐ Atrial Fibrillation ☐ Pacemaker_____yr. ☐ Congestive Heart Failure - Mild - Moderate - Severe
☐ Angioplasty _____yr. ☐ Stent_____yr. ☐ Open Heart Surgery_____yr.

Endocrine:

☐ Diabetes Mellitus ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Hormone Replacement Therapy

Gastro-Intestinal:

☐ Nausea/Vomiting ☐ Poor Appetite ☐ Weight Loss ☐ Constipation ☐ Diarrhea
☐ Black Stools ☐ Acid Reflux ☐ Abdominal Pain ☐ IBS

Hematology/Oncology:

☐ Anemia ☐ Enlarged Lymph Nodes ☐ Hepatitis ☐ HIV
☐ Cancer (Location) _____ ☐ Chemotherapy ☐ Radiation Therapy

Musculoskeletal:

☐ Back Pain ☐ Neck Pain ☐ Joint Swelling ☐ Joint Pain ☐ Polymyalgia
☐ Arthritis ☐ Joint Replacement: _____

Neurological:

☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Fainting ☐ TIA
☐ Seizures ☐ Stroke ☐ Multiple Sclerosis

San Fernando Valley Vascular Group

PATIENT'S NAME: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

THE NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY**.

I acknowledge that I have received the Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available for review at the front desk upon request.

Who may we share your Medical Information with? (Please list the names of ***FAMILY MEMBERS*** and/or ***FRIENDS*** that we may release info to**)**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Where may we leave Medical Information?

Home Answering Machine Phone: _____

Office Voicemail Phone: _____

Cell Phone Phone: _____

☐ **I would like to receive a copy of any amended Notice of Privacy Practices**

By e-mail at: _____

Patient Name: _____

Patient Signature: **X** _____ Date: _____

Patient unable to sign, Representative: _____

If not signed by member, please indicate relationship: _____