Demographic Information

Patient Name:

Mailing address:

City: State: Zip Code:

Home Phone: OK to leave Message: ☐ Brief ☐ Extended

Cell Phone: OK to leave Message: ☐ Brief ☐ Extended

Work Phone: OK to leave Message: ☐ Brief ☐ Extended

Date Of Birth: Sex: Marital Status:

Patient Email:

Spouse's Name: Spouse's Phone:

Do you authorize your spouse to receive information on your behalf? ☐ Yes ☐ No

Social Security Number:

Employer Name: ☐ Full Time ☐ Part Time ☐ Retired ☐ Military

Employer Address:

Employer Phone:

Primary Care Provider: Referring Provider:

Race: ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Black ☐ White ☐ Hispanic ☐ Other

Language Spoken:

Sex: ☐ Male ☐ Female ☐ Transgender Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Emergency Contact Information/ Release of Information

Emergency Contact Name:

Phone Number:

Address:

Relationship to Patient: ☐ HIPAA

Secondary Contact Name:

Phone Number:

Relationship to Patient: ☐ HIPAA

Guarantor/ Responsible Party

Guarantor Name:

Guarantor Phone Number:

Guarantor Date of Birth:

Additional Information

Resuscitation Orders: ☐ Yes ☐ No

Power of Attorney for medical decisions: ☐ Yes ☐ No

Primary Insurance	
Insurance:	
Insured's Name:	Insured's Date of Birth:
Subscriber ID Number:	
Subscriber Address:	
Group Number:	
Insured's Relationship to Patient:	

Secondary Insurance	
Insurance:	
Insured's Name:	Insured's Date of Birth:
Subscriber ID Number:	
Subscriber Address:	
Group Number:	
Insured's Relationship to Patient:	

Additional Billing Information		
Is this worker's Compensation Case?	☐ **Yes** ☐ **NO**	
Worker's Compensation Company:		
Address:		
Phone Number:		
Claim ID:	Date of Injury:	
Case Worker:	Phone Number:	
Attorney:	Firm:	
Attorney's Phone Number:	Attorney's Fax Number:	
Is this Motor Vehicle Accident Case?	☐ **Yes** ☐ **No**	
Automobile Insurance Carrier:	Policy Number:	
Insurance Carrier's Phone Number:		
Insurance Carrier's Address:		
Agent:	Medical Policy Limit:	How much has been met?

I attest that the above information is correct and have read and understand the policies of Atlanta Vascular and Vein Center, LLC and accept my responsibility as stated in those policies. I hereby authorize the release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge. I hereby allow the clinical staff of Atlanta Vascular and Vein Center, LLC to view my medication history from external sources.

Patient, Please sign for permission to treat

Date

Guardian, Please sign fro permission to treat in your absence

Date

MEDICAL QUESTIONAIRE

Patient's Name:	Date of Birth:
Referring Physician:	Primary Care Physician:
Height: Weight:	Dominant Hand: ☐R ☐L
How did you hear about us?	
☐ Established Patient ☐New patient	

PAST MEDICAL HISTORY		
YES	**NO**	
		Diabetes
		Heart Attack
		Heart Failure
		Chest Pain
		Stroke
		Anemia
		Arthritis
		Osteoporosis
		Free/Easy Bleeding
		Ulcers
		Reflux
		Hepatitis
		HIV/AIDS
		High Blood Pressure
		Emphysema
		Asthma
		Anxiety
		Depression
		Insulin _____
		Other _____

ALLERGIES	
NAME	REACTION

YEAR OF SURGERY		
YES	**YEAR**	
		Appendix
		Gall Bladder
		Tonsils
		Tubal Ligation
		Hysterectomy
		C- Section
		Kidney
		Back(Specify)_____
		Neck(Specify)_____
		Knee
		Hip
		Heart Cath
		Heart Bypass
		Other:_____

SOCIAL HISTORY
Occupation:
Marital Status: ☐M ☐S ☐D ☐W
Alcohol Use: ☐Yes ☐No
Tobacco Use: ☐Yes ☐No
Smoker: ☐Yes ☐No
Recreational Drugs: ☐Yes ☐No
Alcohol Abuse: ☐Yes ☐No
Prescription Drug Abuse: ☐Yes ☐No
Illicit Drug Abuse: ☐Yes ☐No
Considerations:

FAMILY HISTORY	IMAGING		
	DATE	TYPE	LOCATION
Heart Attack: ☐Yes ☐No			
Heart Disease: ☐Yes ☐No			
High Blood Pressure: ☐Yes ☐No			
Diabetes: ☐Yes ☐No			
Bleeding Problems: ☐Yes ☐No			
Cancer: ☐Yes ☐No			

MEDICATIONS			
DRUG	DOSE	TIMES PER DAY	WHY
Example: Lortab	*5 mg*	*3*	*Pain*

** PLEASE REMEMBER TO LIST ANY BLOOD THINNERS YOU ARE CURRENTLY TAKING INCLUDING ASPIRIN, COUMADIN, WARFARIN, PLAVIX, PLETAL AGGRENOX, GOODY'S POWDER, LOVENOX, AND PRADAXA **

REVIEW OF SYSTEMS			
Please check all that apply…			
YES		YES	
	Fever/Chills		Vomiting Blood
	Poor Vision		Blood in Stools
	Hard of Hearing		Dark/Tarry Stool
	Glasses and Contacts		Difficulty Swallowing
	Shortness of Breath		Low Blood Sugar
	Easily Fatigued		Fibromyalgia
	Shortness of Breath on Exertion		Muscle disorder
	Coughing Blood		Neurological Disorder
	Chest Pain		Other_____

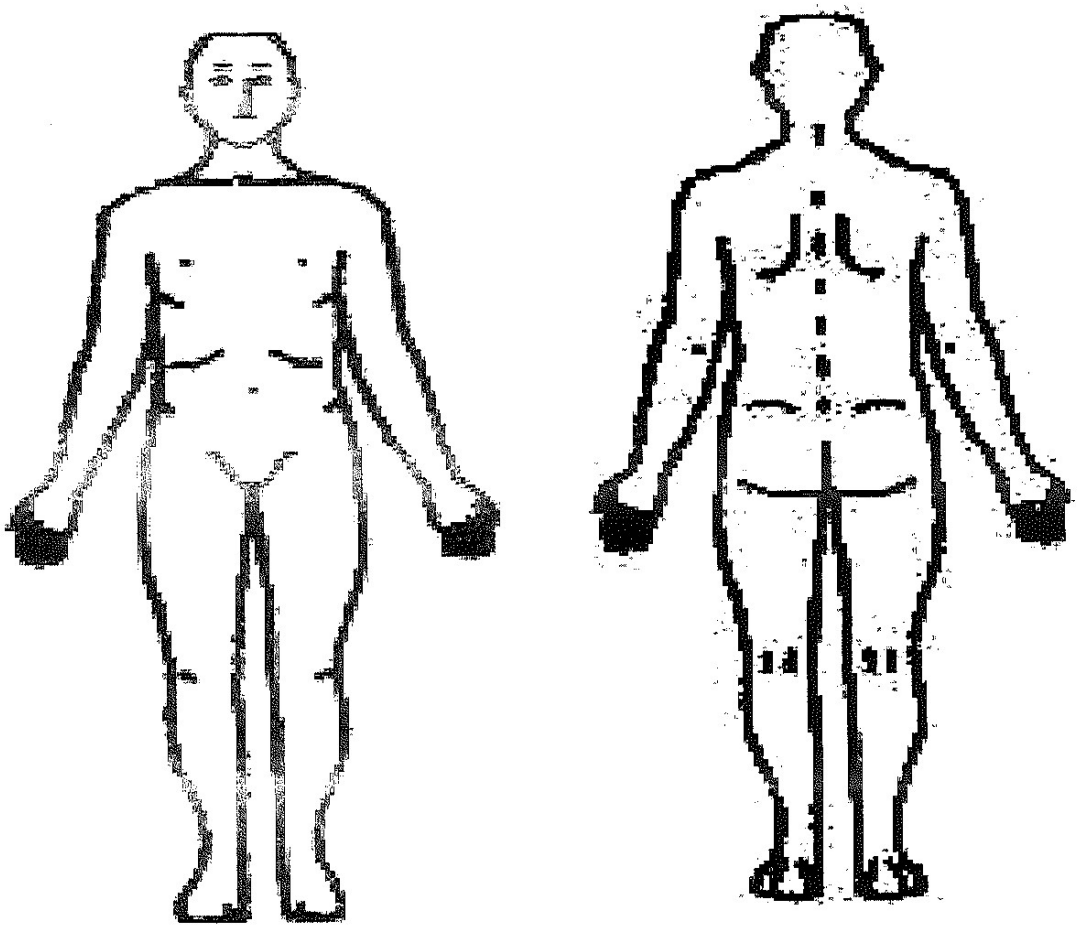
_____ _____

Patient's Signature Date

Family History

Father		
Alive	**Deceased**	
Circle all that applies to your family history		
Diabetes	Hypertension	Heart attack
Stroke	Mental Illness	Cancer
Other _____		
Mother		
Alive	**Deceased**	
Circle all that applies to your family history		
Diabetes	Hypertension	Heart attack
Stroke	Mental Illness	Cancer
Other _____		
Children		
Alive	**Deceased**	**None**
Circle all that applies to your family history		
Diabetes	Hypertension	Heart attack
Stroke	Mental Illness	Cancer
Other _____		
Siblings		
Alive	**Deceased**	**None**
Circle all that applies to your family history		
Diabetes	Hypertension	Heart attack
Stroke	Mental Illness	Cancer
Other _____		

USING THE DIAGRAM BELOW
INDICATE ALL AREAS OF PAIN



Patient's Signature

Date