Seattle Vascular Surgery
EXPERIENCE. COMPASSION. RESULTS.

# NEW PATIENT REGISTRATION FORM

PLEASE DO NOT LEAVE ANY BLANKS.

Patient's Name: _____ Date of Birth: _____ Age: _

Social Security #: _____ Sex: □ Male □ Female Marital Status: □Single □Married □Widowed □ Divorced

**Your social security number is strictly confidential and will solely be used for billing purposes.*

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Home Address: _____

Preferred Language: _____ Race (optional): □ Caucasian □ African American

Do you need an interpreter? □ Yes □ No □ Hispanic □ Asian/ Pacific Islander

Occupation: _____

Employment: □FT □PT □ Retired □ Not Employed □Active Military Duty □ Other: _____

Employers Address:_____

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

Spouse:_____

Referring Physician: _____

Family Physician: _____

Reason for Visit: _____

Emergency Contact: _____

Phone #: _____

Relation: _____

Email address: _____

□Yes, I would like to receive online access to my medical records through Patient Portal

□No, I would not like to receive online access to my medical records

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**Patient Name:** _____ **Date:** _____

## Social History

Alcohol Use: □ Never □ Occasionally □ Daily What do you drink? _____

How many drinks per day? _____

Tobacco Use: □ Current Smoker □ Never Smoked □ Former Smoker □ Occasional Smoker

How much do you smoke? _____ When did you start smoking? _____

*If you quit:* When did you quit? _____ How much did you smoke? _____ For how many years? _____

## Family History

| History of: | | | |
|---|---|---|---|
| Heart Attack | □ Yes | □ No | |
| Stents in the heart | □ Yes | □ No | |
| Bypass surgery | □ Yes | □ No | |
| Other heart problems | □ Yes | □ No | At what age? _____ |
| Aneurysms | □ Yes | □ No | |
| Stroke | □ Yes | □ No | |
| Cancer | □ Yes | □ No | |
| Easy Bleeding | □ Yes | □ No | |
| Arrhythmia | □ Yes | □ No | |
| Reactions to anesthesia | □ Yes | □ No | |
| Sudden death | □ Yes | □ No | |

## Please Provide the Names of Any Other Doctors You Are Currently Seeing:

| | Name (First, Last) | Office Address | Office Phone # |
|---|---|---|---|
| Family Physician | | | |
| Cardiologist | | | |
| Pulmonologist | | | |
| Podiatrist | | | |
| Gastroenterologist | | | |
| Ophthalmologist | | | |
| Endocrinologist | | | |
| Oncologist | | | |
| Other (Specify) | | | |
| Other (Specify) | | | |

**Patient Name:** _____ **Date:**_____

Do you have a pacemaker? □ Yes □ No

Have you ever had any of the following tests?

Stress Test on the heart? □ Yes □ No When/Where? _____

MRI or CT scan? □ Yes □ No When/Where? _____

PET scan? □ Yes □ No When/Where? _____

Angiogram of blood vessels? □ Yes □ No When/Where? _____

Lung function test/pulmonary function test?
□Yes □ No When/Where? _____

Heart catheterization/angiogram?
□ Yes □ No When/Where? _____

## Past Medical History

*Please circle any of the following that apply to you:*

Heart Attack □ Yes □ No
Cancer □ Yes □ No
Poor Circulation □ Yes □ No
Diabetes – On insulin, pills or diet? □ Yes □ No
On dialysis □ Yes □ No
Ever needed dialysis □ Yes □ No
High Blood Pressure □ Yes □ No
Stroke □ Yes □ No

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TIA □ Yes □ No
□ No

Varicose Veins □ Yes

Pain in legs w/ walking □ Yes □ No

Bad reaction to anesthesia – specify: _____

Other: _____

Do you have any prosthetics or implants? □ Yes □ No Specify: _____

**Preferred Pharmacy Name and Phone #:** _____

**Please list all medications you are taking:**
*** Please include other medications such as aspirin, herbs, insulin, eye drops & vitamins*

| Medication | Dose | How Often Do You Take This? | What is it Taken for? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you had a flu shot? □ Yes – When? _____ □ No
Have you had a pneumonia shot? □ Yes – When? _____ □ No
Please list any other recent immunizations: _____

_____

**Are you allergic to any medications, food, environmental, or other substances? **Please specify ALLERGY & REACTIONS:** _____

_____

**Patient Name:** _____ **Date:** _____

**Have you ever had surgery?**
□ Yes □ No

| Surgery | Month/Year | Hospital – City/State |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Have you ever had a serious illness requiring a hospital stay other than surgery?**
□ Yes □ No

| Reason for Hospitalization | Month/Year | Hospital – City/State |
|---|---|---|
| | | |
| | | |
| | | |

# Acknowledgement form

I understand that, under the Health Insurance Policy Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (Our Notice of Privacy Practices). I understand that this information can and will used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly and to obtain payment from third-party payers. I understand that I have the right to review and receive a copy of this Notice before signing this form.

I understand that I may revoke this authorization at any time by submission in writing. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

By signing below, I acknowledge that I have read and understand the terms of this authorization. I hereby knowingly and voluntarily authorize Seattle Vascular Surgery to use or disclose my health information in the manner described above.

Print Name_____ Date_____

Signature _____ Date_____

Witness Name_____ Date_____

Witness Signature_____ Date_____

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

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

May we leave a detailed message on your voice-mail either at work or on a cell regarding personal health information, verifying appointment times, or to change an appointment?
☐ Yes ☐ No

Seattle Vascular Surgery is hereby authorized to discuss my protected healthcare information with the individuals listed below:

Name _____ Name _____

Name _____

# Financial policy

## Please Read Carefully

In non-participating plans, the guarantor is responsible for the difference of usual and customary allowances. In participating plans, the guarantor is responsible for balances as per explanations from the individual's insurance company.

We gladly furnish estimates upon request.

We request that you make payment for all co-payments, deductibles, and office services at the time of your visit. All surgical service balances are expected to be paid within 90 days from the date incurred.

Patients without insurance are asked for a 50% deposit for any elective surgery.

Failure to make payment in full or as stated above or failure to make other financial arrangements for payment will result in your account being placed with a collection agency. You can be charged collection and/or attorney fees which may affect your credit.

We are always available to assist you to collect from your insurance or make payments on your account balance. Your help and cooperation is necessary and appreciated.

I recognize that it is my responsibility to understand my insurance plan and keep Seattle Vascular Surgery informed of any changes.

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Print Name

Signature Date

# Authorization for Release of Information (ROI)
# And
# Assignment of Benefits for Medicare

I request that payment of authorized insurance benefits be made wither to me or on my behalf to Seattle Vascular Surgery, for any services provided to me by the physician or supplier. I authorize any holder of medical information about me to release to my insurer and its agent to determine these benefits payable for related services.

I understand that my physician and/or staff will not release any information to my family members or me without verification of my identity in order to comply with privacy regulations. I also understand that information will be released to other healthcare professionals for the coordination of my care/treatment and/or health insurance carriers in the event that it is necessary to process a claim.

By my signature, I state that I have read, understand, and agree to this authorization and release.

Print Name

Signature Date