Vascular Care Specialists
LOS ANGELES

612 W. Duarte Rd. #303, Arcadia, CA 91007
Phone: 626-275-9566 | Fax: 626-387-4188
www.vcsla.com

PATIENT INFORMATION

Full Name: _____ **Date of Birth:** _____ **Age:** _____
(First) (Middle) (Last)

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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

Home Phone #: _____ **Cell Phone #:** _____

Email Address: _____ **Preferred Language:** _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined

Race: ☐ Asian ☐ American Indian ☐ African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Hispanic or Latino ☐ Other ☐ Unknown/Declined

Emergency Contact Information:

Name: _____ Relationship: _____ Phone: _____

Referring Physician's Information **Physician's Name:** _____

Physician's Address: _____

Physician's Phone #: _____ **Physician's Fax #:** _____

Primary Care Physician's Information **Physician's Name:** _____

Physician's Address: _____

Physician's Phone #: _____ **Physician's Fax #:** _____

Insurance Information

Primary Insurance: _____ **Certificate #:** _____

Group #: _____ **Group Name:** _____ **ID #:** _____

Secondary Insurance: _____ **Certificate #:** _____

Group #: _____ **Group Name:** _____ **ID #:** _____

Pharmacy Information

Pharmacy Name: _____ **Address:** _____

Phone #: _____ **Fax #:** _____

Dialysis Information ☐ **Not Applicable**

Dialysis Center: _____ **Address:** _____

Phone #: _____ **Fax #:** _____

Dialysis Days (please circle): **Mon Tue Wed Thur Fri Sat** **Contact Name:** _____

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Past Medical History (please circle answer):

Condition			Year of Onset
Coronary Artery Disease	Yes	No	
Diabetes	Yes	No	
Hypertension	Yes	No	
Stroke	Yes	No	

Condition			Year of Onset
Chronal Renal Failure	Yes	No	
High Cholesterol	Yes	No	
Obesity	Yes	No	
COPD (Chronic Obstructive Pulmonary Disease)	Yes	No	

Past Surgical History (including hospitalization and cardiovascular procedures):

Surgery Type	Date	Doctor/Hospital

Allergies: ☐ Yes ☐ No _____

Social History:

Do you smoke? ☐ Yes ☐ No How much? _____
Are you a former smoker? ☐ Yes ☐ No Year quit: _____
Do you drink alcohol? ☐ Yes ☐ No Frequency? _____

Family History (Please circle answer if your immediate/blood relatives had the following conditions)

Condition			Family Member
Coronary Artery Disease	Yes	No	
Diabetes	Yes	No	
Hypertension	Yes	No	
Stroke	Yes	No	
Bleeding Tendency	Yes	No	
Varicose Veins	Yes	No	

Condition			Family Member
Cancer	Yes	No	
High Cholesterol	Yes	No	
Obesity	Yes	No	
Gout	Yes	No	
Arthritis	Yes	No	
Peripheral Artery Disease	Yes	No	

Medication List:

Medication Name	Dose / Frequency

Medication Name	Dose / Frequency

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Review of Systems (Check all that you are currently experiencing):

	CARDIOVASCULAR
	Chest pain or palpitations
	Shortness of breath
	Difficulty walking two blocks
	heart murmur
	EARS, EYES, NOSE, THROAT
	Do you wear glasses?
	Change in vison
	Change in hearing
	Frequent sneezing
	Nosebleeds
	RESPIRATORY:
	Shortness of breath while walking
	Cough
	Wheezing
	GASTROINTESTINAL:
	Bloody bowel movements
	Recent change in bowel habits
	Frequent diarrhea
	Heartburn or indigestion

	GENITOURINARY:
	Frequent urination
	Burning/painful urination
	Blood in urine
	Kidney stones
	MUSCULOSKELETAL:
	Joint pain
	Joint swelling
	Injuries to joint
	fractures
	SKIN:
	Hives
	Eczema
	Rash
	Abnormal pigmentation
	NEUROLOGICAL:
	Fainting spells
	Convulsions
	Paralysis
	Headaches

	PSYCHIATRIC:
	Depression
	Anxiety
	Hallucination
	ENDOCRINE:
	Excessive thirst
	Frequent urination
	Intolerant to heat/cold
	HEMATOLOGIC:
	Anemia
	Excessive bleeding
	Excessive bruising
	Swollen glands
	IMMUNOLOGY/ALLERGY:
	Itchy eyes
	Runny noes
	GENERAL:
	Fevers or chills
	Night sweats
	Recent weight change

I understand that the above information is required to provide me with the proper medical care in a safe and effective manner. I have completed the questions to the best of my knowledge. Should further information be needed, I give my consent to ask the respective healthcare provider agency to release any necessary information. I will notify the doctor of any changes in my health or medication.

_____
Patient Name (Print)

_____ _____
Patient or Guardian/Legal Representative Signature Date

_____ _____
Physician Signature Date

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Disclosure of Protected Health Information

I have been provided and have reviewed the Notice of Privacy Practice which provides a complete description of the uses and disclosures of certain medical information. I understand that as part of the provision of medical services, Vascular Care Specialists of Los Angeles creates and maintains health records (in written, oral, or electronic format) for medical treatment, payment, health care operations, and all other purposes outlined in the Notice of Privacy Practice.

_____ (initials) I authorize the release of any medical information necessary to process any claim. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance company or me at any time, in writing, except where disclosure have already been made on my prior consent.

Notice of Financial Responsibility

I have been provided and have reviewed the Notice of Patient Financial Responsibility which describes my financial obligations. I understand that Vascular Care Specialists of Los Angeles will submit billing for medical services, as a courtesy, to my insurance carriers but I am ultimately responsible for the payment for all medical services provided.

_____ (initials) I understand that I am financially responsible to the physician for all charges.

_____
Patient Name (print)

_____ _____
Patient or Guardian/Legal Representative Signature Date

_____ _____
Witness Signature Date

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CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY/E-PRESECRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety.

By authorizing Vascular Care Specialists of Los Angeles, you allow us to view your external prescription history.This will provide the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and staff here, and it may include prescriptions back in time for several years.

By signing this consent form, you are agreeing that Vascular Care Specialists of Los Angeles can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

_____

Patient Name (Print)

_____ _____

Patient or Guardian/Legal Representative Signature Date