Vascular
SURGICAL SPECIALISTS, PLLC

Sean V. Ryan, MD, MBA
Scott R. Golarz, MD, FACS
Daniel C. Lee, MD
Daniel J. Hayes, MD
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NEW PATIENT PAPERWORK

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____

DATE OF BIRTH: _____/_____/_____ **AGE:** _____ **SEX:** _____ **MALE** _____ **FEMALE**

HOME ADDRESS _____ **CITY, STATE, ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____

EMAIL: _____ **PREFERRED METHOD OF CONTACT:** ____**HOME** ____**CELL** ____**EMAIL**

REASON FOR VISIT: _____ **REFERRING PROVIDER:** _____

PRIMARY CARE PROVIDER: _____ **CARDIOLOGIST:** _____

ARE YOU A DIALYSIS PATIENT: _____**YES** _____**NO** **IF YES, PLEASE LIST NEPHROLOGIST:** _____

PHARMACY: _____ **CONTACT NUMBER:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP TO PATIENT:** _____ **PHONE NUMBER:** _____

PRIMARY INSURANCE: _____ **SECONDARY INSURANCE:** _____

PLEASE NOTE: IF YOUR INSURANCE REQUIRES A REFERRAL TO BE SEEN, PLEASE CONTACT YOUR PRIMARY CARE PHYSICIAN AND HAVE THEM SEND A REFERRAL PRIOR TO YOUR VISIT WITH US. IT IS UP TO THE PATIENT TO DISCERN IF A REFERRAL WILL BE NECESSARY

FINANCIAL RESPONSIBILITY: *Vascular Surgical Specialists, PLLC participate with most major health insurance plans. It is the patient's responsibility to check with their insurance company to confirm our clinic and providers are in network. The patient is also responsible for knowing their insurance benefits as insurance plans, policies, and coverages vary. We will gladly file your medical visit to the insurance companies we participate with. Failure to provide accurate and up to date insurance information may result in the full balance due from the patient. We will not become involved in disputes between you and your insurance company regarding coverage or benefit criteria such as deductibles, co-pays, co-insurance, non-covered services, and coordination of benefits. You are responsible for all coinsurance, deductible, and copay amounts assessed by your insurance company(s). Co-payments are due at the time of service. Please note patients that are unable to provide proof of coverage or do not have health insurance will be required to pay for services the day of their appointment. We accept cash, personal checks, money orders, Visa, Discover, Amex and MasterCard.*

Signature: _____ ***Date:*** _____

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MEDICAL HISTORY

PATIENT NAME: _____ WEIGHT: _____ HEIGHT: _____

ALLERGIES: _____

CURRENT SMOKER: ____YES _____ NO- IF YES, PACKS PER DAY_____, _____ # OF YEARS

FORMER SMOKER: _____ YES _____NO- IF YES, YEAR QUIT_____

ALCOHOL USE: _____ YES _____ NO- IF YES, FREQUENCY _____

CURRENT MEDICATIONS (NAMES & DOSE):

_____ _____ _____ _____

_____ _____ _____ _____

PLEASE LIST ANY PREVIOUS SURGICAL PROCEDURES AND DATES:

_____ _____ _____ _____

_____ _____ _____ _____

HAVE YOU OR ANYONE IN YOUR FAMILY HAD A PROBLEM WITH ANESTHESIA? _____ YES (PLEASE EXPLAIN) _____ NO

_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

HIGH BLOOD PRESSURE _____ HIGH CHOLESTEROL _____ DIABETES _____

CORONARY ARTERY DISEASE_____ STROKE_____ ASTHMA _____

HEART ATTACK _____ PHLEBITIS _____ KIDNEY DISEASE_____ ;TYPE_____

THYROID DISEASE _____ CANCER _____;TYPE: _____ ERECTILE DYSFUNCTION _____

VENOUS THROMBOSIS (DVT) _____ SLEEP APNEA _____ ESOPHAGEAL REFLUX _____

ATHEROSCLEROSIS _____ COPD _____ SEIZURE DISORDER _____

OSTEOPOROSIS _____ MENTAL ILLNESS _____ BLOOD DISORDER_____; TYPE_____

HEPATITIS _____ OTHER: _____

DOES ANYONE IN YOUR FAMILY HAVE THE FOLLOWING

HEART DISEASE: _____ RELATION:_____ CANCER: _____; TYPE_____RELATION_____

STROKE: _____ RELATION: _____ HIGH BLOOD PRESSURE: _____ RELATION:_____

VARICOSE VEINS: _____ RELATION: _____ DIABETES: _____ RELATION: _____

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CURRENT MEDICAL HISTORY

TODAY'S DATE: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ARE YOU CURRENTLY HAVING ANY OF THE FOLLOWING SYMPTOMS?

GENERAL SYMPTOMS
SIGNIFICANT WEIGHT GAIN OR LOSS _____
(IF SO ,CIRCLE GAINED/ LOST _____ #LBS)
CHANGE IN APPETITE _____
FEVER ____
CHILLS _____
TIRING EASILY/WEAKNESS_____

ENDOCRINE
HEAT/COLD INTOLERANCE_____
EXCESSIVE THIRST _____
EXCESSIVE SWEATING _____

SKIN
SORES THAT DON'T HEAL _____
COLOR CHANGES TO HANDS AND/OR FEET _____
LESIONS OR RASHES _____
HAIR LOSS _____

ENT
HEARING LOSS _____
NOSE BLEEDS _____
DIFFICULTY SWALLOWING _____
BLEEDING GUMS _____
MOUTH SORES _____
THROAT PAIN _____
HOARSENESS _____
NECK LUMPS OR GOITER _____
NECK PAIN OR STIFFNESS _____

EYES
GLASSES OR CONTACTS _____
LOSS OF VISION _____
DOUBLE OR BLURRED VISION _____

CARDIOVASCULAR
CHEST PAIN OR DISCOMFORT _____
IRREGULAR OR FAST HEART RATE _____
PALPITATIONS _____
SWOLLEN LEGS _____

RESPIRATORY
COUGH _____
SHORTNESS OF BREATH: _____
WHEEZING_____

GASTROINTESTINAL
HEARTBURN OR GERD_____
ULCER _____
NAUSEA _____
ABDOMINAL PAIN _____
BOWEL CHANGES _____

GENITOURINARY
FREQUENT URINATION _____
PAINFUL URINATION_____
BLOOD IN URINE_____
INCONTINENCE_____

MUSCULOSKELETAL
BACK PAIN _____
JOINT PAIN_____
JOINT STIFFNESS_____
MUSCLE ACHE_____

NEUROLOGIC
EPISODES OF DIFFICULTY SPEAKING____
NUMBNESS OR TINGLING_____
DIFFICULTY MOVING ARMS/LEGS_____
DIZZINESS OR VERTIGO_____

HEMATOLOGIC/LYMPHATIC
EASILY BRUISE_____
BLEED A LONG TIME_____
SWOLLEN GLANDS_____

PSYCHOLOGICAL
DIFFICULTY WITH SLEEP_____
ANXIETY_____
DEPRESSION_____
_

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HIPAA-PATIENT DISCLOSURE AUTHORIZATION

I CONFIRM THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM VASCULAR SURGICAL SPECIALISTS, LLLC. UNDER FEDERAL LAW 104-191, ALSO KNOWN AS HIPAA, I AM ENTITLED TO RECEIVE A COPY OF THIS NOTICE FROM MY HEALTHCARE PROVIDER.

_____ _____
PATIENT NAME **DATE OF BIRTH (MM/DD/YYYY)**

_____ _____
SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF UNDER 18) **DATE**

☐ **I HEREBY AUTHORIZE VASCULAR SURGICAL SPECIALISTS TO CONTACT ME OR LEAVE A MESSAGE REGARDING MY MEDICAL INFORMATION.**

☐ **I HEREBY AUTHORIZE VASCULAR SURGICAL SPECIALISTS TO SHARE MEDICAL INFORMATION WITH THE PERSON(S) LISTED BELOW.**

PLEASE INDICATE BELOW THE NAMES, RELATIONSHIP AND PHONE NUMBER OF ANY FAMILY MEMBERS OR FRIENDS TO WHOM WE MAY DISCLOSE YOUR MEDICAL INFORMATION:

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER