COASTAL VASCULAR & INTERVENTIONAL, PLLC

PATIENT INFORMATION

Last Name	First Name	Middle	M F SEX	Date of Birth	Age

Soc. Security #	Race	M S W D O Marital Status	Referring Physician	Primary Care physician

Address	City/State/Zip

Home Phone	Work Phone	Cell Phone	Email Address

RESPONSIBLE PARTY (Who is the primary medical insurance policy holder and is responsible for your account?)

Last Name	First Name	Middle	Relationship to Patient

Date of Birth	Social Security #	Employer/ Occupation
		/

Address (If different from patient)	City/State/Zip

Home Phone	Work Phone	Cell Phone

INSURANCE: Please give your insurance card(s) to our office staff so we may copy them.

Primary _____
ID# _____
Group # _____ Effective Date ___/ ___ /___
Policy Holder _____
Relationship _____ DOB ___/ ___ /_____
SS# ____- _____- _____ Employer _____

Secondary _____
ID# _____
Group # _____ Effective Date ___/ ___ /_____
Policy Holder _____
Relationship _____ DOB ___/ ___ /_____
SS# ____- _____- _____ Employer _____

IN CASE OF EMERGENCY, Contact:

Name (Someone not living with you)	Address	Phone Number	Relationship

Name (Someone not living with you)	Address	Phone Number	Relationship

PATIENT SIGNATURE _____ DATE: _____

Reviewed & Updated: _____ **Date:** _____

COASTAL VASCULAR & INTERVENTIONAL, PLLC

ASSIGNMENT OF BENEFITS

I _____ _____ herby authorize _____
Patient or Financially Responsible Party (Please Print) Date of Birth Name of Insurance Carrier

To make medical benefits payments, otherwise payable to me for services rendered by Coastal Vascular & Interventional payable to and mailed directly to Coastal Vascular & Interventional, PLLC. I hereby irrevocably assign to Coastal Vascular & Interventional the rights and benefits under any policy of insurance, indemnity, agreement, or any other collateral source as defined in Florida Statutes for any service and/or changes, provided by the practice. I the undersigned by these presents does herby make, constitute and appoint Coastal Vascular & Interventional and any of it duly authorized agents to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts, or money orders, that are made payable tot the undersigned alone or to the undersigned and said practice's which checks, drafts, or money orders are made payable for services which have been made by the practice, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order. I the undersigned allows Coastal Vascular & Interventional or any of its agents to sign any paper that will be necessary to enhance, expedite, and/or allow payment to said provider. This may include insurance forms and other statements.

MEDICAL RELEASE

I agree that a photocopy of this document shall be sufficient to authorize any person having record of medial treatment, services, or supplies pertaining to me to release true copies of same to Coastal Vascular and Interventional or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be binding as an original signature page.

FINANCIAL RESPONSIBILITY

Co-Pays, Deductibles and fees for non covered services are due at the time of service. If after your claim has been filed with your insurance company, a patient responsibility amount is due you will receive a statement of your financial responsibility will be sent to you. Failure to pay the patient responsibility may result in your account being assigned to a collection agency. If your account is turned over to collections, you will be responsible for your balance and the collection company's current fee. If collection efforts fail, your account may be turned over to an attorney for legal action.

CONSENT TO TREAT

I authorize Coastal Vascular & Interventional to perform the treatments or procedures approved by my physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. The nature and purpose of the procedure, possible alternative methods of treatment and risk involved and the possibilities of complications have been fully explained to me.

PATIENT AUTHORIZATION TO THE USE AND DISCOSURE OF PROTECTED INFORMATION (PHI) FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

You may email my records to: _____

You may release my PHI to:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Leave a message on my answering device ☐ Yes ☐ No Release my Psychological History: ☐ Yes ☐ No

You may mail a letter to my home address to relay normal Ultrasound results. ☐ Yes ☐ No

Release my HIV status ☐ Yes ☐ NO Release my Alcohol and Substance Abuse History ☐ Yes ☐ No Other: _____

_____ _____ ____/____/____
Patient's Signature Patient's Printed Name Date

_____ _____ _____
Witness Signature Witness Printed Name Date

Reviewed & Updated: _____ **Date:** _____

COASTAL VASCULAR & INTERVENTIONAL, PLLC

MEDICAL HISTORY

Patient Name:_____ **Date of Birth** _____ **Today's Date** _____

How did you hear about us? ☐ Referring Physician ☐ Television ☐ Yellow Pages ☐ Hospital Call Center ☐ Internet ☐ Ad

What are you being seen for today? _____

When did this start?_____ Have you been treated for this problem before? ☐ Yes ☐ No By Dr._____

MEDICAL HISTORY and Problems: Please circle all that apply

Anemia	No	Yes	Angina	No	Yes	Arthritis	No	Yes
Alcoholism	No	Yes	Asthma	No	Yes	Bleeding Problems	No	Yes
Blood Diseases	No	Yes	Blood Clots	No	Yes	Colitis	No	Yes
Congestive Heart Failure	No	Yes	Diverticulitis	No	Yes	Diabetes	No	Yes
Emphysema	No	Yes	Gallbladder Disease	No	Yes	Hernia	No	Yes
High Cholesterol	No	Yes	High Blood Pressure	No	Yes	HIV Positive	No	Yes
Heart Disease	No	Yes	Kidney Failure	No	Yes	Mitral Valve Prolapse	No	Yes
Seizure	No	Yes	Stroke	No	Yes	Ulcers	No	Yes

Cancer: (Type) _____ Hepatitis (Type) _____ Heart Attack When? _____

Weight Loss/Gain how Much _____ Stress Test When? _____

REVIEW OF SYSTEMS: Please circle all that apply today

General:			**Respitory:**			**Genital/Intestinal:**		
Increased Fatigue	No	Yes	Cough	No	Yes	Painful Urination	No	Yes
Trouble Sleeping	No	Yes	Shortness of breathe	No	Yes	Frequency	No	Yes
Sweats	No	Yes	Difficulty Breathing	No	Yes	Urgency	No	Yes
Chills	No	Yes	COPD	No	Yes	Nighttime Urination	No	Yes
Ear/ Nose/ Throat:			Emphysema	No	Yes	Bloody Urine	No	Yes
Earache	No	Yes	**Cardio/Vascular:**			**Musculoskeletal:**		
Ringing in ears	No	Yes	Chest Pain	No	Yes	Back Pain	No	Yes
Hearing loss	No	Yes	Palpitations	No	Yes	Joint Pain	No	Yes
Sore throat	No	Yes	Syncope	No	Yes	Joint Swelling	No	Yes
Post nasal drip	No	Yes	PND	No	Yes	Muscle Pain	No	Yes
Runny nose	No	Yes	Edema	No	Yes	Altered Gait	No	Yes
Facial Pressure	No	Yes	**Gastro Intestinal:**			Decreased Range of motion	No	Yes
Eyes:			Vomiting	No	Yes	**Skin:**		
Visual Changes	No	Yes	Heart Burn	No	Yes	Rash	No	Yes
Blurring	No	Yes	Reflux	No	Yes	Itching	No	Yes
Double Vision	No	Yes	Diarrhea	No	Yes	Dryness	No	Yes
Loss	No	Yes	Constipation	No	Yes	Ulcers	No	Yes
Pain	No	Yes	Black Stool	No	Yes	Bleeding Under the Skin	No	Yes
Endocrine:			Abdominal Pain	No	Yes	Bruising	No	Yes
Heat Intolerance	No	Yes	**Neurology:**			**Psychology:**		
Increase Thirst	No	Yes	Weakness	No	Yes	Depression	No	Yes
Increase Hunger	No	Yes	Abnormal Sensation	No	Yes	Anxiety	No	Yes
Hyme/Lymph/ID			Painful Skin	No	Yes	Panic	No	Yes
Abnormal Bleeding	No	Yes	Seizures	No	Yes	Memory Loss	No	Yes
Bruising	No	Yes	Tremors	No	Yes	Agitation	No	Yes

Patient Name:_____ **Date of Birth** _____ **Today's Date** _____

Reviewed & Updated: _____ **Date:** _____

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SURGICAL HISTORY

Surgery/Procedure	Year	Facility	Surgeon

Have you ever had any complication with surgery? _____

FAMILY HISTORY : Please list family relationship. (Father, Mother, Sister, Brother)

☐ Aortic Aneurysm Relationship to:_____ ☐ High Blood Pressure Relationship to:_____

☐ Stroke Relationship to: _____ ☐ Cancer (Type) _____Relationship to: _____

☐ Brain Tumors Relationship to:_____ ☐ Migraine Relationship to: _____

☐ Epilepsy Relationship to:_____ ☐ Brain Hemorrhage Relationship to:_____

☐ Asthma Relationship to:_____ ☐ Allergies Relationship to:_____

☐ Diabetes Relationship to:_____ ☐ Heart Disease Relationship to:_____

☐ Varicose Veins Relationship to:_____ ☐ Other _____Relationship to:_____

DIALYSIS PATIENTS

Are You Currently on Dialysis ☐ Yes ☐ No If YES what days do you have dialysis? MWF TTS Other _____

What is the Name and Number of the Dialysis Unit? _____

SOCIAL HISTORY

Have you ever smoke tobacco: ☐ Yes ☐ No How much per day _____ When did you quit _____

Have you every taken any drugs not prescribed by a physician ☐ Yes ☐ No What? _____

Do you consume Alcohol? ☐ Yes ☐ No

If YES How much Per day or Week ? _____ What Type? ☐ Beer ☐ Wine ☐ Liquor

Do you exercise? ☐ Yes ☐ No? How often? _____ Type of Exercise _____

Do you have Children ☐ Yes ☐ No How many children do you have (women only)? _____

Occupation:_____

Reviewed & Updated: _____ **Date:** _____

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Patient Name:_____ **Date of Birth** _____ **Today's Date** _____

DIABETES

Are you a Diabetic ☐ Yes ☐ No Are you insulin dependent? ☐ Yes ☐ No Is it diet controlled? ☐ Yes ☐ No

PREFERED PHARMACY: NAME: _____ LOCATION: _____ PHONE # _____

DRUG ALLERGIES:

Please list any drug allergies you have and the type of reaction:

_____

_____

Have you ever had a reaction to IVP dye, or have an allergy to shell fish, sea food or Benadryl? _____

Are you allergic to Latex? _____

MEDICATIONS Please list all medications you are presently taking.

MEDICATION	Mg.	DOSAGE	MEDICATION	Mg.	DOSAGE

Reviewed & Updated: _____ **Date:** _____