Patient Registration Form

Patient Name: First______________________ MI _____ Last________________________ **Sex:** ☐ F ☐ M

DOB:_________ **Social Security #**_____________ **Marital Status:** Single Married Divorced Widowed

Address:____________________________________ **Apt#**_____ **City**________________ **St**_____ **Zip** ________

*If in a nursing home or rehab please specify:*____

Primary Phone:___________________________ ☐ Home ☐ Cell ☐ Work ☐ Nursing Home ☐ Rehab

Secondary Phone:_________________________ ☐ Home ☐ Cell ☐ Work ☐ Nursing Home ☐ Rehab

Email: ___________________________________ **Preferred Language:** ☐ English ☐ Spanish

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White

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

Pharmacy Name & Address:______________________________ **Pharmacy Phone#**______________________

Please contact your pharmacy for medication refills. Your pharmacy will fax us a refill request which the physician will review. Refill authorizations may require 48-72 hours.

Primary Care Physician:__________________________________ **Phone#**________________________________

Referring Physician:_____________________________________ **Phone#**________________________________

How did you hear about our practice? ☐ Physician Referral ☐ Friend/Family ☐ Hospital ☐ Ad/Magazine ☐ Internet

INSURANCE INFORMATION

Primary Insurance:_________________________ Policy ID#______________________ Group#_____________

Claims Mailing Address: ____

Policy Holder Name: _________________________ Relationship: Self Spouse Parent Other:

Policy Holder DOB: _________________________ Policy Holder SS#___________________________________

Secondary Insurance:_______________________ Policy ID#______________________ Group# _____________

Claims Mailing Address: ____

Policy Holder Name:_________________________ Relationship: Self Spouse Parent Other:

Policy Holder DOB:__________________________ Policy Holder SS#___________________________________

Please Note: *So that we may maintain the most up to date and accurate information on our patients, we may request that you review and update this form at least once a year.*

Patient Medical History

PATIENT FULL NAME: ________________________________ DOB: ________________
HEIGHT: _____________ **WEIGHT:** ___________
Medication Allergies: ____________________________

Please list ALL medication(s) with DOSAGE & QUANITY you are currently taking:

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

Medical History (Circle all that applies): ***If NONE apply please check the box*** ☐

Atrial Fibrillation	Blood Clots	Cancer	Emphysema	Diabetes
High Cholesterol	Hypertension	Hypothyroidism	Kidney Failure	
Heart Disease	Varicose Veins	Spider Veins	Stroke	

Surgeries/Procedures and Year:

____

____

Family History (Circle all that applies): ***If NONE apply please check the box*** ☐

Atrial Fibrillation	Blood Clots	Cancer	Emphysema	Diabetes
High Cholesterol	Hypertension	Hypothyroidism	Kidney Failure	
Heart Disease	Varicose Veins	Spider Veins	Stroke	

Social History:
Occupation: _________________ **Marital Status:** ________________
Current smoker? YES/NO **(Circle One)** How many years total? ____ **# Packs/Day**
If quit, when? ___________________
Alcohol use? YES/NO **(Circle One)** Recreational Drugs? YES/NO **(Circle One)**

Review of Systems (Circle all that applies): ***If NONE apply please check to box*** ☐

Fever	Weight Loss (>30lbs)	Shortness of Breath	Loss of Vision
Snoring	Coughing up Blood	Chest Pain	Syncope (Passing out)
Heart Attacks	Blood Clots	Substance Abuse	Prolonged Bleeding
Pacemaker	Stent(s)	Pain in Extremities	Leg Swelling
Leg Pain	Non-healing Wounds	Abdominal Pain	Bloody Stool
Blood in Urine	Kidney Disease	Confusion	Ulcer(s)
Back Pain	Arthritis	Gout	Rash
Lesion(s)	Abnormal Vaginal Bleeding		

VANGUARD VASCULAR & VEIN
RESTORING FLOW

Consent to Treat

I hereby authorize Vanguard Vascular & Vein to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

______________________________ ______________________________ ____________________
Patient Name (Please Print) **Signature of Patient or Legal Guardian** **Date**

Financial Responsibility

I hereby authorize that by signing this I agree to have received a copy of Vanguard Vascular & Vein patient's financial responsibilites and agree to all the terms and conditions outlined to its entirety. I hereby authorize payment of medical services directly to Vanguard Vascular & Vein and/ or the attending physician for services rendered. I hereby authorize the release of patient medical records to medical insurance companies (and its representing agents) as it may be necessary for processing and completion of the patient's insurance medical claim. I understand that this authorization may include the following; release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I will be held responsible for the total charges in FULL for services rendered which may include services not covered by the patient's insurance plan and or companies. I agree that all amounts are due upon request and are payable to Vanguard Vascular & Vein.

The duration of this authorization is indefinite and shall remain so unless otherwise revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full prior to the services being rendered.

______________________________ ______________________________ ____________________
Patient Name (Please Print **Signature of Patient or Legal Guardian** **Date**

Approved HIPAA Contacts

Our number one priority is to keep our patients information private and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**.
If you would like to add additional contacts (other than parent or legal guardians) that Vanguard Vascular & Vein is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like Vanguard Vascular & Vein to list as your **Emergency Contact i**n the event of an emergency.

Do you have an Advanced Directive? YES NO

#1. ______________________ ______________________ ______________________ ☐ Billing
Contact Name **Relationship to Patient** **Contact Phone Number** ☐ Medical

#2. ______________________ ______________________ ______________________ ☐ Billing
Contact Name **Relationship to Patient** **Contact Phone Number** ☐ Medical

The duration of this authorization is indefinite and shall remain so unless otherwise revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full prior to the services being rendered.

______________________________ ______________________________ ____________________
Patient Name (Please Print) **Signature of Patient or Legal Guardian** **Date**

Acknowledgement of Receipt

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and how medical information can be used by our staff in providing and arranging your medical care.

The Patients Bill of Rights list of guarantees for those receiving medical care. It may be in form of a law or a non-binding notice. Typically this form guarantees protection of patient's information, fair treatment, and autonomy over medical decisions, among other rights.

Vanguard Vascular & Vein is to provide you with a copy of the attached notices, which provides information about how Vanguard Vascular & Vein and its physicians may use and/or disclose protected health information about you for treatment, payment, health care decisions and or as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy and understand the HIPAA and Patient Bill of Rights.

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Patient Name (Please Print)

____ ____________________

Signature of Patient, Parent, or Legal Guardian **Date**

Patient Preferences Regarding Communication of Health Information

My preferred method of communication regarding my medical conditions is indicated below (check one):

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Parent or Legal Guardian

If the above method of communication is by phone, please check the appropriate box below:

☐ Leave a message with detailed information which may include medical information, billing information or any other information needing to be relayed to the patient.

☐ Leave a message with a call back number only

Please inform our office if you have any special directions and/or request regarding our communication with you or if you do not wish to be contacted at all.

Authorization for Release of Information to Vanguard Vascular & Vein

___________________________________	_____________	___________________________
Patient Name (Please Print)	Date of Birth	Social Security Number
____		___________________________
Patient Address, City, State, Zip		Phone Number

I hereby authorize: ____
Name of Physician/Clinic/Hospital you want to release your records

____
Address, City, State, & Zip Code of Physician/Clinic/Hospital

______________________ ______________________
Phone Number Fax Number

Information to be released: *(Circle all that apply)*

Complete Medical Records Radiology Reports (Ultrasounds, CTAs) Consultations

Laboratory Reports Operative Records Other:_______________

The medical records of the above named patient shall be released to:

Vanguard Vascular & Vein
Dr. Franklin Yau Dr. Ruosu An
7700 Lakeview Parkway Suite C
Rowlett, Tx 75088
Phone: 972-487-1818 Fax: 972-487-7928

I understand that I have the right to revoke this authorization at any time with a written request to the physician but until then this authorization shall be in effect until further revoked. I understand that the revocation will not apply to information that has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.*

____ ____________________
Signature of Patient, Parent, or Legal Guardian **Date**