

New Patient History Form

What brings you to our office today?

When did this problem begin? _____

Any previous treatments or testing for this issue? Yes No

What was done? _____ When? _____ Where? _____

Primary Care Physician? _____

How did you hear about our practice? _____

Friend Family Doctor Print Ad Internet Other

Medications

Are you currently taking any blood thinners? Yes No

Please list any medications you are currently taking.

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____

Allergies

Are you allergic to any of the following? Please check all that apply.

Adhesive Tape Aspirin Contrast IV Dye Latex Sulfa
 Antibiotics Codeine Iodine Local Anesthetics

Do you have any other allergies? Please list.

Name _____ Reaction _____

Name _____ Reaction _____

Physical Characteristics

Weight _____ Height _____

Past Medical History

Have you ever been diagnosed with any of the following medical conditions? Please check all that apply.

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other (Please list)
<input type="checkbox"/> Allergies	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Anemia	<input type="checkbox"/> Gout	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizure Disorder	_____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis (B or C)	<input type="checkbox"/> Skin Disorder	_____
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stomach Ulcer	_____
<input type="checkbox"/> Back Problems	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Substance Abuse	_____
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Thyroid Disorder	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Vascular Intervention	_____
<input type="checkbox"/> Depression	<input type="checkbox"/> Migraines		_____

Women Only

Are you, or do you think you may be pregnant? Yes No Are you breastfeeding? Yes No

Past Surgical History

Type of Surgery _____ Date _____ Surgeon _____
Type of Surgery _____ Date _____ Surgeon _____

Social History

Tobacco Never Quit Yes # Packs/Day _____
If quit, how long ago? _____
For how long? _____

Alcohol Never Quit Yes # Drinks/Day _____
If quit, how long ago? _____
For how long? _____

Recreational Drugs Never Quit Yes Type _____
If quit, how long ago? _____
Frequency? _____

Review of Systems

General Health

Fever Yes No
Chills Yes No
Fatigue Yes No
Weight Loss Yes No

Eyes

Blurry or Double Vision Yes No
Eye Disease or Injury Yes No

Ear/Nose/Throat

Hearing Loss Yes No
Nose Bleeds Yes No
Swollen Glands in Neck Yes No

Cardiac

Chest Pain or Angina Yes No
Shortness of Breath Yes No
Irregular Heartbeat/Palpitations Yes No

Respiratory

Chronic or Frequent Coughs Yes No
Spitting Up of Blood Yes No
Wheezing/Asthma Yes No

Gastrointestinal

Change in Bowel Habits Yes No
Loss of Appetite Yes No
Nausea/Vomiting Yes No
Diarrhea Yes No
Constipation Yes No
Rectal Bleeding/Blood in Stool Yes No

Genito/Urinary

Frequent Urination Yes No
Blood in Urine Yes No

Circle all that apply

Musculo-Skeletal

Back Pain Yes No
Muscle Weakness Yes No
Joint Pain Yes No

Skin

Rash/Itching Yes No
Leg Ulcer Yes No
Skin Lesion Yes No
Discoloration Yes No

Neurologic

Headache Yes No
Dizziness Yes No
Seizures Yes No
Numbness Yes No

Psychiatric

Depression Yes No
Anxiety Yes No
Memory Loss Yes No

Endocrine

Heat/Cold Issues Yes No

Lymphatic/Blood

Feeling Cold & Tired Yes No

Vascular

Open Wounds Yes No
Known AAA Yes No
Varicose Veins Yes No
Leg Swelling Yes No
Leg Pain Yes No

Circle all that apply

Venous Health Form

What brings you to our office today?

Please check all that apply to describe your current condition.

- Red Spider Veins
 - Skin Discoloration Below Knee
 - Purple Veins
 - Varicose Veins
 - Bulging Veins
 - Bluish-Green Veins
 - Leg Ulcers
 - Leg Swelling
 - Leg Injury
 - Bleeding
 - Open Wound
 - Other
-

Please check if you experience any of the following in your legs. If so, please describe when this happens. Check all that apply.

- Tiredness/Fatigue
 - Itching/Burning
 - Swollen Legs
 - Leg Cramps
 - Restless Legs
 - Throbbing
 - Bleeding
 - Night Cramps
-
-

Please check any methods you have used to try to relieve your leg discomfort. Check all that apply.

- No Discomfort
- Leg Elevation
- Exercise
- Flexion/Extension
- Walking
- Compression Stockings
- Cold Packs
- Pain Meds
- Aspirin
- Tylenol
- Ibuprofen
- Wraps

Treatment History

Yes No Have you ever been treated at a Wound Care Clinic?

If yes, where are you being treated? _____

Who is your wound care physician? _____

Yes No Have you ever been treated for any leg vein condition? If yes, by what method? Check all that apply.

- Injections
- Radiofrequency Closure
- Ultrasound Guided Injections
- Laser for Catheter Ablation
- Ambulatory Phlebectomy
- Ligation
- Laser for Spider Veins
- Other

If yes, please explain:

Yes No Have you ever been diagnosed with saphenous vein reflux? _____

Yes No Do you have a family history of varicose veins, ulcers or clotting disorders? _____

Yes No Do you have a history of clotting disorders, phlebitis, bleed from the vein, etc? _____

Yes No Have you ever had testing done for clotting disorders? _____

Yes No Have you ever had a vascular ultrasound test done on your legs? If so, when and where? _____

Yes No Have your veins gotten worse in recent months? _____

Release of Patient Information

Consent Form

Release Information to:

South Bay Vascular Center & Vein Institute
2255 S. Bascom Ave, Suite 200 • Campbell, CA 95008
Phone: 408-376-3626 • Fax: 408-871-2377

Polyxene G. Kokinos MD. PC. RPVI. Board Certified Vascular and General Surgeon, Endovascular Specialist
Ignatius H. Lau MD. Board Certified Vascular Surgeon

Identifying Information:

Patient Name (Please Print): _____ Date of Birth: _____

Information Requested:

Attending Physician: _____ Date(s) of Treatment: _____

_____ History & Physical _____ Procedure Report _____ Discharge Summary _____ CD

_____ Other: _____

Please Initial:

_____ I hereby authorize South Bay Vascular Center to obtain the above-named individual or company with all medical data and information they may request, as listed above, concerning my procedure/treatment.

_____ This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate six (6) months from the date of consent without express revocation.

_____ I hereby consent to the release of any and all records containing alcohol and/or drug abuse and/or psychiatric diagnosis under the same consideration as outlined above. I understand that such information cannot be released without my specific consent, except in accordance with a court order.

_____ I further understand that I have a right to receive a copy of this authorization upon request.

Copy Requested: Yes No

Copy Received: Yes No

Signature of Patient/Parent/Legal Guardian _____ Date _____

Patient Address _____ City _____ State _____ Zip Code _____

Patient Demographics

Name: _____ Date of Birth: _____ Age: _____
Male Female Married Single Widowed Divorced Separated
Social Security Number: _____ How did you find us?: _____
Who is your primary care doctor? _____
Home/Mailing Address: _____ City: _____
State: _____ Zip Code: _____ E-mail Address: _____
Home Phone: (____) _____ Cell Phone: (____) _____
Would you like access to our **online** patient portal, where you can request appointments, request prescription refills, make payments on your account, and send messages to our office? (Please circle) Y / N
Preferred Method of Contact: Home Phone Cell Phone Patient Portal Letter
Preferred Language: _____ Ethnicity: _____

Emergency Contact

Full Name: _____ Relationship: _____ Phone: (____) _____

Primary Insurance Information

Primary Insurance _____
ID # _____ Group # _____
Subscriber Name: _____ Subscriber DOB: _____ Relation to Pt: _____

Secondary Insurance Information

Primary Insurance _____
ID # _____ Group # _____
Subscriber Name: _____ Subscriber DOB: _____ Relation to Pt: _____

I certify that I (and/or my dependent(s)) have insurance coverage with the above named insurance company and assign directly to the selected provider of South Bay Vascular Center and Vein Clinic all insurance benefits, if any, payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize the provider to release information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. My signature certifies I have received the HIPPA information.

I give permission for Dr. Kokinos and staff to call me by phone, e-mail, voicemail message, and/or postal mail to confirm appointments and provide me with other information related to my health.

Name (Please Print): _____ Signature: _____ Date: _____

Financial Policy

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment. All patients must complete and sign the appropriate documents.

YOUR INSURANCE COMPANY REQUIRES PROOF OF INSURANCE BE PRESENTED FOR ALL SERVICES PROVIDED. IF PROOF OF INSURANCE IS NOT PRESENTED, REGRETTABLY, PAYMENT AT THE TIME OF SERVICE WILL BE REQUIRED. IT IS THE RESPONSIBILITY OF EACH PATIENT TO INFORM US OF ANY CHANGES IN INSURANCE, PLACE OF EMPLOYMENT, AND/OR ADDRESS AND PHONE NUMBERS. WE WILL REQUEST A PATIENT INFORMATION UPDATE TO BE COMPLETED ONCE A YEAR. ALL COPAYS MUST BE PAID AT THE TIME OF SERVICE.

PPO: Our office submits a claim to your insurance company. The balance after your insurance payment is your responsibility. Please pay all copays and deductibles at the time of service.

HMO: Our office will submit an insurance claim to your insurance company. Obtaining an initial authorization for services is the responsibility of the patient and/or referring physician's office. If an authorization is not obtained, charges will be the responsibility of the patient at the time of the appointment. Please be aware that HMOs require our office to collect all non-covered services and copays from the patient.

Private Insurance: Our office will bill your services to your primary insurance company as a courtesy. Full payment is due at the time of service if benefits are not verified or proof of insurance is not presented. Any balance not covered by insurance after 60 days is considered due and payable.

Patients Without Insurance: Full payment is due at the time of service. Payment arrangements are available if coordinated with our business office prior to the visit.

Missed Appointments: Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments as follows: \$75 for office visit; \$100 for office procedure or ultrasound; up to \$500 for surgery center procedure. Please help us serve you better by keeping scheduled appointments.

Copies Of Medical Records: There is a charge for copying medical records. There is a fee of \$0.45 per page copied, plus reasonable clerical fees of \$24.00/hour (charged in quarter hour increments), which includes the time spent in locating, acquiring and copying the actual records, plus postage fees. The records will not be sent until the fee is paid. These fees are set by the State of California (Health & Safety Code section 123110), not the South Bay Vascular Center or the Institute for Vascular Testing.

Phone Calls: It is not the office policy to call patients with test results. If you request a phone call, the charge will be \$25.00 for every fifteen minutes.

Cosmetic Fees: Payments made for cosmetic consult may be applied to cosmetic treatment up to 6 months after the initial consult.

Interest is charged at 8% per year on accounts with a patient responsibility balance.

I have read, understand, and agree to the contents of this Financial Policy.

Name (Please Print): _____ Signature: _____ Date: _____

Acknowledgement of Privacy Practices & Privileged Medical Information

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be 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
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications
- Call home, work, or cell phone to confirm or reschedule appointments
- Leave a message on answering machine

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of its *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I, _____, give South Bay Vascular Center permission to speak to the family members and/or friends listed below regarding my privileged medical information. I may change and update my list whenever I wish by submitting a request to the office in writing.

Name of person

Relationship

NOT APPLICABLE

Name (Please Print): _____ Signature: _____ Date: _____

Signature: _____

**South Bay Vascular Center
& Vein Institute**
PREMIER CENTER OF EXCELLENCE

Phone: 408-376-3626 Fax: 408-871-2377
Web: SouthBayVascular.com
Locations: Campbell • Gilroy