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

Do you have any 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.

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Continued on reverse ▶

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_____
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	**Circle all that apply**	
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 Appetitie	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

Musculo-Skeletal	**Circle all that apply**	
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

South Bay Vascular Center & Vein Institute
PREMIER CENTER OF EXCELLENCE

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

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

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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 • Dr. Aamna M. Ali 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 _____

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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 Patient: _____

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 contact 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: _____

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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 ultrasound; $200 for office procedure; 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: _____

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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): _____ Date: _____

Signature: _____

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