# COASTAL VASCULAR & INTERVENTIONAL, PLLC

**PATIENT INFORMATION**

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

Soc. Security # ______ Race ______ Marital Status M S W D O ______ 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:** ____________________________

# COASTAL VASCULAR & INTERVENTIONAL, PLLC

## 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:** ______________________________________

## COASTAL VASCULAR & INTERVENTIONAL, PLLC

**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 |
|---|---|---|---|---|---|
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**Reviewed & Updated:** ________________________________________________________ **Date:** _________________________________________