

# VERO VASCULAR SURGERY, P.A.

W. Clark Beckett, M.D., F.A.C.S.

Board Certified Vascular Surgeon

3770 7<sup>th</sup> Terrace, Suite 101 \* Vero Beach, Florida 32960 \* 772.567.6602 \* Fax 772.567.7754

Date: \_\_\_\_\_

## PATIENT HISTORY FORM

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Chief Complaint/Symptoms: \_\_\_\_\_

PCP/ Referring MD/other physicians: \_\_\_\_\_

Current Medications: **\*\*Please include dosage and instructions for taking your medications\*\***

**\*\*\*\* You may provide your own list if you have one\*\*\*\***

_____	_____
_____	_____
_____	_____
_____	_____

Allergies: ( ) Yes ( ) No If yes, please list \_\_\_\_\_

Surgeries: (Include Dates) **\*\*\*\* You may provide your own list if you have one\*\*\*\***

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. Tobacco Use: Yes: \_\_\_\_ No: \_\_\_\_ Never: \_\_\_\_ How much: \_\_\_\_\_

Age Started: \_\_\_\_ Age Quit: \_\_\_\_ Years Smoked: \_\_\_\_ Year Quit: \_\_\_\_\_

Type: Cigarette: \_\_\_\_ Pipe: \_\_\_\_ Cigars: \_\_\_\_ Chew: \_\_\_\_ Marijuana: \_\_\_\_\_

2. Alcohol Use: Yes: \_\_\_\_ No: \_\_\_\_ How Much: \_\_\_\_ How often: \_\_\_\_ Year Quit: \_\_\_\_\_

Type: Beer: \_\_\_\_ Wine: \_\_\_\_ Liquor: \_\_\_\_\_

3. Exercise: Yes: \_\_\_\_ No: \_\_\_\_ Describe: \_\_\_\_\_

Are you currently on Dialysis? ( ) Yes ( ) No If yes, please list what facility and shift \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Nurse will record below

Blood Pressure Left \_\_\_\_\_ Right \_\_\_\_\_ Pulse \_\_\_\_\_

Stocking Size: \_\_\_\_\_ Ankle \_\_\_\_\_ Calf \_\_\_\_\_ Thigh \_\_\_\_\_ Length \_\_\_\_\_ Photos taken: \_\_\_\_\_

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## MEDICAL HISTORY: (Please check all that apply)

<b><u>GENERAL:</u></b>	Yes	No	<b><u>RESPIRATORY:</u></b>	Yes	No
Headaches	_____	_____	Shortness of breath	_____	_____
Dizziness	_____	_____	At rest	_____	_____
Blurred/Double Vision	_____	_____	With exertion	_____	_____
Cataracts	_____	_____	Chronic Cough	_____	_____
Recent weight gain/loss	_____	_____	COPD	_____	_____
			Asthma	_____	_____
<b><u>NEUROLOGICAL:</u></b>	Yes	No	Wheezing	_____	_____
Seizure History	_____	_____	Coughing up blood	_____	_____
Paralysis	_____	_____	Chronic or No lung Disorder	_____	_____
Tremors	_____	_____	Pneumonia	_____	_____
TIA's (mini stroke)	_____	_____			
Stroke	_____	_____	<b><u>DIGESTIVE:</u></b>	Yes	No
Parkinson's	_____	_____	Heart Burn	_____	_____
Alzheimer's	_____	_____	Nausea/Vomiting	_____	_____
Weakness	_____	_____	Constipation	_____	_____
Loss of consciousness	_____	_____	Ulcer Disease	_____	_____
Numbness	_____	_____	Abdominal Pain	_____	_____
Balance problems	_____	_____	Vomiting Blood	_____	_____
Peripheral Neuropathy	_____	_____	Bloody/Black stool	_____	_____
(Numbness/ tingling in legs)			Liver Disease	_____	_____
<b><u>CARDIOVASCULAR:</u></b>	Yes	No	<b><u>KIDNEY/ BLADDER: GENITOURINARY</u></b>	Yes	No
Chest Pain/pressure	_____	_____	Frequent Urination	_____	_____
High Blood Pressure	_____	_____	Incontinence	_____	_____
High Cholesterol	_____	_____	Difficulty Urination	_____	_____
Congestive Heart Failure	_____	_____	Kidney Disease	_____	_____
Heart Attack	_____	_____	Kidney Stones	_____	_____
Irregular Heart Beat	_____	_____	Blood in urine	_____	_____
Murmur	_____	_____			
Palpitations(Racing heartbeat)	_____	_____	<b><u>MUSCLES/ BONES/ JOINTS:</u></b>	Yes	No
Leg swelling			Back Pain	_____	_____
Chronic (Present long time)	_____	_____	Muscle Weakness	_____	_____
New onset	_____	_____	Arthritis	_____	_____
			Osteoporosis	_____	_____
<b><u>VASCULAR:</u></b>	Yes	No	Joint pain/swelling	_____	_____
Varicose Veins	_____	_____			
Spider Veins	_____	_____	<b><u>HEMATOLOGY/ ONCOLOGY/ ENDOCRINE:</u></b>	Yes	No
Deep Vein Clot	_____	_____	Anemia	_____	_____
Superficial Vein Clot	_____	_____	Easy bruising	_____	_____
Pulmonary Embolus (clot in lungs)	_____	_____	Clotting disorder	_____	_____
			Cancer	_____	_____
Calf/ thigh cramps with walking	_____	_____	-Leukemia	_____	_____
Wounds/ulcers	_____	_____	Diabetes	_____	_____
? slow healing	_____	_____	Thyroid Disorder	_____	_____

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## MEDICAL HISTORY (CONTINUED)

### IMMUNE SYSTEM/ INFECTIOUS DISEASE:

	Yes	No
Hepatitis	___	___
MRSA infection	___	___
Jaundice	___	___
HIV/Aids	___	___
Tuberculosis	___	___

### PSYCHIATRIC:

	Yes	No
Depression	___	___
Anxiety	___	___
Poor Appetite	___	___
Hallucination	___	___

### Family Medical History:

Please list age and any medical conditions.

If deceased, age of death

Father: \_\_\_\_\_

\_\_\_\_\_

Mother: \_\_\_\_\_

\_\_\_\_\_

Brother: \_\_\_\_\_

\_\_\_\_\_

Sister: \_\_\_\_\_

\_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_

Do you have any other Health care concerns not mentioned previously:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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## SECTION A: PATIENT INFORMATION

Date: \_\_\_\_\_

NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ INITIAL \_\_\_\_\_

PATIENT SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE: \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL (if patient is a minor) \_\_\_\_\_

CURRENTLY WORKING: YES \_\_\_\_\_ NO \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

## SECTION B: SPOUSE INFORMATION

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SOC.SEC.# \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

## SECTION C: IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

How did you hear about us? (Circle one) Friend Physician Other \_\_\_\_\_

## SECTION D: PREFERRED PHARMACY

Name: \_\_\_\_\_ Location: \_\_\_\_\_

## SECTION E: \*\*PLEASE BRING YOUR PHOTO ID & INSURANCE CARDS\*\*

### PRIMARY INSURANCE

### SECONDARY INSURANCE

INS.CO.NAME \_\_\_\_\_ INS.CO.NAME \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

We request the following information to better treat medical conditions which may be related to these items and to ensure communication is clear. Please take a moment to answer each of these.

Race: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Ethnicity: (Circle one) Hispanic or Non-Hispanic or Other \_\_\_\_\_

By signing below, I authorize Vero Vascular Surgery, PA to bill and receive payment from the insurance(s) provided for services rendered. I understand that I am ultimately responsible for these charges and may be billed for amounts not paid by my insurance company. I also understand that it is my responsibility to provide updated insurance information should my coverage change. Failure to pay for any medical services can result in those charges being forwarded to a collection agency.

Patient/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

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## AUTHORIZATION TO RELEASE MEDICAL/FINANCIAL INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, in order for your physician or the staff of **Vero Vascular Surgery, PA (VVS)** to give copies of and/or discuss your condition, exams, procedures, x-rays and financial information with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

- I DO NOT authorize VVS to release any information concerning my care to any individual.**
- I authorize VVS to release any/all information including verbal information, copies of x-rays, medical paperwork and financial information concerning my medical care to the following individuals.**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

## AUTHORIZATION TO LEAVE PHONE MESSAGE

- I authorize VVS to leave detailed messages at  Home phone  Cell phone**
- I DO NOT authorize VVS to leave a detailed message on my answering machine or voicemail. I acknowledge in choosing this option that I, the patient/Guardian, assume full responsibility for contacting VVS regarding any/all testing results.**

## MEDICATION ACCESS AUTHORIZATION

- I authorize VVS to obtain/download medication information from my pharmacy.**
- I DO NOT authorize VVS to obtain/download medication information from my pharmacy. I acknowledge by choosing this option, I may be limiting my quality of care.**

## RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how VVS may use and disclose my protected health information. I understand that VVS reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

Print Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## PATIENT PORTAL

Our office provides patients with access to their medical record electronically through our Patient Portal. You are also able to email us directly, request appointments, and cancel appointments. If you would like to be signed up for our portal please provide us with your email address and preferred username.

Email: \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

Username: \_\_\_\_\_ (8 characters minimum)

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## LIVING WILL/ ADVANCED HEALTH CARE DIRECTIVE

- I currently have a Living Will or Advanced Directive
- I DO NOT have a Living Will or Advanced Directive

If you currently have a living will, please provide us with the following information as well as a copy of the document for our records.

Health Care Surrogate:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

## CONSENT TO TREATMENT

***TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Physician Assistant), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Patient or Representative

\_\_\_\_\_  
Relationship to patient