

1850 Sullivan Ave, Suite 300
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MELINDA L. AQUINO, MD
Board Certified Vascular Surgeon
<http://www.sfveincenter.com>

1 Shrader Street, Suite 400
San Francisco, CA 94117
Phone 650-991-1122
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PATIENT DEMOGRAPHICS

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Soc Sec #: _____

Home Phone: _____ Cell Phone: _____

E-Mail Addr: _____

Emergency Contact: _____

Relationship: _____ Emergency Phone: _____

Primary Physician: _____

How did you hear about us?

- I came from a doctor or hospital
- website - sfveincenter.com
- Yelp

Referring Physician: _____

PATIENT MEDICAL HISTORY

Name _____ Date _____ Age _____

What brings you to our office today?

What medical problems do you have? For example: high blood pressure, varicose veins, diabetes, etc.

What hospitalizations and surgeries have you had in the past?

Approx Date	Surgery	Hospital	Surgeon

What medications do you take?

Medication	Dose/Frequency	Medication	Dose / Frequency

PATIENT MEDICAL HISTORY (PAGE 2)

Name _____

Are there any medical conditions that run in your family?

Condition	Relation

What allergies do you have?

Allergy	Reaction

Have you ever smoked?

Yes No

If you have smoked, how many packs a day?

How many years did you smoke?

Have you stopped?

Yes No

If you have stopped smoking. When did you stop?

How many alcoholic drinks do you have a day?

Have you ever had a problem with alcohol?

Yes No

What do you do for work?

PATIENT MEDICAL HISTORY (PAGE 3)

Name _____

The following is a checklist called the "Review of Systems." It is a tool physicians use to jog your memory so we don't overlook any medical issues you may have. It may seem cumbersome, but it's important! Please take the time to fill in this sheet.

REVIEW OF SYSTEMS (check any boxes that apply)

General / Endocrine

Weight Change	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	Sweats	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>
Chills	<input type="checkbox"/>	Fevers	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Loud Snoring	<input type="checkbox"/>

HEENT

Loss of Eyesight	<input type="checkbox"/>	Sinus Infection	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	Neck stiffness	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	Ear Infection	<input type="checkbox"/>

Gastrointestinal

Stomach Pain	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	Constipation	<input type="checkbox"/>

Urologic

Blood in Urine	<input type="checkbox"/>	Nightly Urination	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>
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Musculoskeletal

Weakness	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Muscle Aches	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>
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Neurologic

Tremors	<input type="checkbox"/>	Difficulty Speaking	<input type="checkbox"/>	Numbness	<input type="checkbox"/>
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Respiratory

Cough	<input type="checkbox"/>	NWheezing	<input type="checkbox"/>	Coughing Blood	<input type="checkbox"/>
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Cardiac

Chest Pain	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>
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Hematologic

Bleeding Tendencies	<input type="checkbox"/>	Blood Clots in Legs	<input type="checkbox"/>	Blood Clots in Lungs	<input type="checkbox"/>
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Skin

Rashes	<input type="checkbox"/>	Itching	<input type="checkbox"/>	Change in Skin	<input type="checkbox"/>
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Psychiatric

Depression	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>
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Pulmonary

Asthma	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Cough	<input type="checkbox"/>
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PATIENT HEALTH INFORMATION AUTHORIZATION AND CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we require you to read and sign this form stating that you understand and agree with how your health information will be used, your authorization to use that information, and your rights regarding that information.

Notice of Privacy Practices

I acknowledge that I have been provided with this office's Notice of Privacy Practices. I understand that it provides a complete description of the uses and disclosures of my health information. I understand that a copy of the Notice of Privacy Practices is also available at the front desk as well as <http://www.sfveincenter.com>.

Authorization for the Disclosure of PHI for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment.
- a means of communication among the health professionals who may contribute to my healthcare.
- a source of information for applying my diagnosis and surgical information to my bill.
- a means by which a third-party payer can verify that services billed were actually provided.
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified above.

Consent to the Use and Disclosure of PHI for Treatment, Payment, or Healthcare Operations

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent.
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested.
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Patient or Legal Representative Signature

Printed Name

Date

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions. We are pleased to discuss our financial policy with you at any time.

General responsibilities

You (or patient's guardian) are responsible for the payment of your treatment and care.

Insurance

- Your insurance policy is a contract between you and your insurance provider. You are responsible for understanding and paying your insurance copays, deductibles, and coinsurance. Our staff is happy to explain what these are if you need help.
- As a courtesy, we bill your insurance company for you and charge you copays, deductibles, and/or coinsurance as instructed by your insurance company.
- As a courtesy, we try to verify coverage and eligibility. However, it is your responsibility to determine if the doctor is in-network prior to being seen.
- You are responsible for providing us with the most correct and updated information about your insurance.
- You are responsible for any amounts not covered by insurance.

Self-pay discounts

Please understand that we take care to ensure that our self-pay charges are equivalent to the average payments allowed by insurance companies. By doing this, we safeguard the patient from getting charged more than an insurance company will pay (on average) for a given service. Please talk to our staff about our self-pay charges if you haven't already.

Cancellations

While we understand there may be times when you miss an appointment due to emergencies or obligations, we require a 24 hour notice on all cancelled appointments. A \$50 fee will be applied towards all no-show office visits.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees.

Patient or Legal Representative Signature

Printed Name

Date