Seton Medical Center
1850 Sullivan Ave, Suite 300
Daly City, CA 94015
Phone 650-991-1122
Fax 415-744-1199

MELINDA L. AQUINO, MD
Board Certified Vascular Surgeon
http://www.sfveincenter.com

St Marys Medical Center
2250 Hayes Street Ste 612
San Francisco, CA 94117
Phone 415-752-1122
Fax 415-744-1199

PATIENT DEMOGRAPHICS

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

Home Phone: _____

Cell Phone: _____

E-Mail Addr: _____

Emergency Contact (Next of Kin) _____

Phone: _____

Relationship: _____

Primary Physician: _____

How did you hear about us? Please choose one option.

- (•) I came from a doctor or hospital — Referring Physician: _____
- ( ) Web Search / Google / www.sfveincenter.com
- ( ) Yelp

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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	☐	Difficulty Sleeping	☐	Sweats	☐	Fatigue	☐
Chills	☐	Fevers	☐	Dizzyness	☐	Loud Snoring	☐

HEENT

Loss of Eyesight	☐	Sinus Infection	☐	Headaches	☐	Nose Bleeds	☐
Hearing Loss	☐	Neck stiffness	☐	Difficulty Swallowing	☐	Ear Infection	☐

Gastrointestinal

Stomach Pain	☐	Ulcers	☐	Bloody Stools	☐	Heartburn	☐
Nausea	☐	Diarrhea	☐	Black Stools	☐	Constipation	☐

Urologic

Blood in Urine	☐	Nightly Urination	☐	Impotence	☐	Kidney Stones	☐

Musculoskeltal

Weakness	☐	Joint Pain	☐	Muscle Aches	☐	Back Pain	☐

Neurologic

Teremors	☐	Difficulty Speaking	☐	Numbness	☐

Respiratory

Cough	☐	NWheezing	☐	Coughing Blood	☐

Cardiac

Chest Pain	☐	Heart Palpitations	☐	Heart Attack	☐

Hematologic

Bleeding Tendencies	☐	Blood Clots in Legs	☐	Blood Clots in Lungs	☐

Skin

Rashes	☐	Itching	☐	Change in Skin	☐

Psychiatric

Depression	☐	Panic Attacks	☐	Anxiety	☐

Pulmonary

Asthma	☐	Allergies	☐	Cough	☐

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Cancellation policy
While we understand there may be times when you miss an appointment due to emergencies or obligations, we enforce the following cancellation policy:

- **We require at least a 48 hour (2 business days) notice to cancel an office appointment. A $50 fee will be charged for cancellations made less than 48 hours (2 business days) from the appointment time or missed appointments.**

- **We require at least a 48 hour notice to cancel a procedure. A $100 fee will be charged for cancellations made less than 48 hours from the procedure time or if the procedure is missed. Procedures require special preparation of equipment and a procedure room which is reserved.**

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 curtesy, we bill your insurance company for you and charge you copays, deductibles, and/or coinsurance as instructed by your insurance company.
- As a curtesy, 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.

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.

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

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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