520-994-8464 ph
520-994-8474 fax

One Vascular

Welcome to our office! Please fill out this form completely. Thank you!		
Name:	Date of Birth:	Today's Date:
Mailing Address:	City, State:	Zip Code:
Preferred Telephone #1	Telephone #2	Sex: M or F
Circle One: Single	Married	Email:
Person Authorized to disclose protected health information:	Relationship:	Phone:
Responsible Party Name & Address:	Referring Doctor Name:	
Primary Care Doctor Name		
Primary Insurance:		
Policy Holder Name:	Policy Holder Birthdate:	Relationship to Patient:
Policy #:	Group #:	
Secondary Insurance:		
Policy Holder Name:	Policy Holder Birthdate:	Relationship to Patient:
Policy #	Group #	

Privacy Policy: By signing this form, I am consenting to One Vascular use and disclosure of my Protected Health Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been advised that the Notice of Privacy Practices are posted and copies are available upon request.

Referrals: One Vascular is contracted with several carriers, which require appropriate referrals. Obtaining this referral is your responsibility. If seen without the necessary referral, you are liable for any charges.

Authorization of Insurance Benefits: I authorize payment benefits, otherwise payable to me, be paid to One Vascular. I understand that I am financially responsible for charges not covered by this assignment. I authorize the refund of over-paid insurance benefits when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including attorney fees. This release of medical information and assignment of benefits are considered in force from the date of signing until revoked in writing.

Signature:_____

Date:_____

(Patient's Signature or Guardian's Signature if Patient is a Minor)

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Nickname:_____ DOB:_____

Primary Care Physician:_____ Referring/Specialty Dr:_____

Pharmacy:_____ Location (street & city)_____

Race: ◊ American Indian or Alaska Native ◊ Asian ◊ Black or African American ◊ Native Hawaiian or Other Pacific Islander ◊ White

Ethnicity: ◊ Hispanic ◊ Not Hispanic

Preferred Language: ◊ English ◊ Spanish

Allergies: Reaction Severity

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

Are you Allergic to Shellfish or Contrast Dye: Yes No

Medical History: (please mark all that apply)

Type 1 Diabetes	Heart Attack	Pacemaker
Type 2 Diabetes	Stroke	ICD
High Blood Pressure	Mini Stroke	Loop Recorder Implant
Elevated Cholesterol	Coronary Artery Disease	
Elevated Triglycerides	Cartoid Disease	

Other Significant Illnesses: (please mark all that apply)

Overall Healthy	AIDS	
Graves Disease	Lupus	
Rheumatoid Arthritis	Mutiple Sclerosis	Other

Current Medications (please list)

_____ _____ _____ _____

_____ _____ _____ _____

Systemic Illnesses:

◊ No History of Illness	◊ Congestive Heart Failure	◊ Hepatitis	◊ Lung Disease
◊ Anemia	◊ COPD	◊ High Blood Pressure	◊ Arthritis
◊ High Cholesterol	◊ Migraine	◊ Arrythmia	◊ Eczema
◊ Polymyalgia	◊ Asthma	◊ Fibromyalgia	◊ Kidney Disease
◊ Bleeding Disorder	◊ Psychiatric Disorder	◊ Headache	◊ Kidney Stones
◊ Skin Cancer	◊ Cancer	◊ Hearing Loss	◊ Liver Disease
◊ Stroke	◊ Thyroid Disease	◊ Other	

General Surgeries / Operations: (please list)

_____ _____ _____ _____

_____ _____ _____ _____

Infections: (please mark all that apply)

◊ Overall Healthy	◊ Herpes Simplex	◊ Herpes Zoster/Shingles	◊ Hepatitis A /B / C
◊ MRSA	◊ Other_____		

Family History:

- Arthritis
- Blindness
- Cancer
- High Blood Pressure
- Diabetes
- Glaucoma
- Hearth Disease
- Retinal Disease
- Kidney Disease
- Lazy Eye
- Macular Degeneration
- Other_____
- Stroke
- TB
- Cataracts

Social History: (please mark all that apply)

Smoking: current every day smoker | current some day smoker | former smoker | never smoked

Alcohol Use: Yes No If yes, how much and how often:_____

Drug Use: Yes No If yes, what and how often:_____

Review of Systems: (please mark all that apply)

EYES
- Previous Surgery
- Contact Lens
- Pain
- Double Vision
- Glaucoma
- Cataracts
- Macular Degeneration
- Dry Eyes
- Flashes
- Floaters

EAR, NOSE & THROAT
- Ringing in ears
- Vertigo

CARDIOVASCULAR
- Chest Pain
- Dizziness
- Fainting Spells
- Shortness of Breath
- Irregular Heartbeat
- Difficulty Lying Flat

CONSTITUTIONAL
- Fatigue / Weakness
- Fever
- Weight Gain / Loss

RESPIRATORY
- Cough
- Congestion
- Wheezing
- Asthma

GASTROINTESTINAL
- Heartburn
- Nausea / Vomiting
- Jaundice / Hepatitis

GENITO-URINARY
- Pain / Difficulty
- Blood in Urine
- History of Kidney Stones
- History of STD's

PSYCHIATRIC
- Anxiety / Depression
- Difficulty Sleeping

ENDOCRINE
- Increased Thirst
- Increased Hunger
- Increased Urination
- Increased Sweating
- Fingernail Changes

BLOOD/LYMPHNODES
- Easy Bruising
- Gums Bleed Easy
- Prolonged Bleeding
- Heavy Aspirin Use

MUSCULOSKELETAL
- Stiffness
- Arthritis
- Joint Pain / Swelling

SKIN
- Rash / Sores
- Lesions
- Hives / Eczema

NEUROLOGICAL
- Seizures
- Weakness / Paralysis
- Numbness
- Tremors

IMMUNOLOGIC
- Hives
- Itching
- Runny Nose
- Sinus Pressure