SOUTHEAST VASCULAR GROUP

PATIENT INFORMATION SHEET

NAME:____**S.S#**:______________________

ADDRESS:____

CITY:__________________________________**STATE**:____________**ZIP**:________________

PHONE:_____________________**WORK**:___________________**CELL**:_________________

DATE OF BIRTH:___________________________ **SEX** (circle one): **MALE** **FEMALE**

SPOUSE'S NAME: ____

EMERGENCY CONTACT: _____________________________ **PHONE**: _______________

ALLERGIES: ____

BLOOD THINNERS: (circle one) **YES** ____________________ **NO**

DIABETIC: (circle one) **MEDICATON** **INSULIN**

FAMILY PHYSICIAN: ____

REFERRED BY: ____

INSURANCE INFORMATION

1) PRIMARY INSURANCE: ____

SUBSCRIBER'S NAME: _____________________________SUBSCRIBER'S D.O.B.:________________________

2) SECONDARY INSURANCE: ____

SUBSCRIBER'S NAME: _____________________________SUBSCRIBER'S D.O.B.:________________________

IS THIS A WORKMANS COMP VISIT? ____

WORKMANS COMP CARRIER____

WHAT DAYS DO YOU HAVE DIALYSIS (please circle below):

Monday Tuesday Wednesday Thursday Friday Saturday

WHERE DO YOU GO FOR DIALYSIS: ____

Date: ____________________ Name:____

1. Are You:
   a. ☐ Right Handed
   b. ☐ Left Handed
   c. ☐ Ambidextrous (Right & Left handed)

2. Do You Smoke: ☐ Yes ☐ No How Much? ___________________________

3. Do you consume alcoholic beverages? ☐ Yes ☐ No

   How much? _____________________________________

4. Do you take any type of diet pills? ☐ Yes ☐ No

   What type? _____________________________________

5. What medications are you taking? List: Name, dosage, and how often you take the medications and name of prescribing physician.

Medication Name:	Dosage:	How Often:	Name of Prescribing Physician

Patients Name: ____Date: __________________

6. Have you had any operations? List: kind of operation, year operation was done, and Surgeons name.

Type of Operation	**Year done**	**Where**	**Surgeons Name**

7. Check illness and list member of your ***immediate family*** (mother, father, brother, sister) who have had any of the following:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Cancer (type)
- ☐ Diabetes mellitus (sugar diabetes)
- ☐ Allergies
- ☐ Asthma
- ☐ Epilepsy
- ☐ Migraine
- ☐ Stroke
- ☐ Brain tumors
- ☐ Aneurysms
- ☐ Brain hemorrhage

8. Have you had any of the above illnesses or any serious illness in the past, please list the illness and year below:

____

____

____

____

9. Allergies: ____

Patients Name: ____Date: __________________

These questions pertain to the patient only. Please answer the following questions by answering "**No**" for never experienced, "**Recent**" for current symptoms and "**Past**" for symptoms you have experienced in the past.

Neurological	No	Recent	Past
FAINTING SPELLS	☐	☐	☐
SEIZURES	☐	☐	☐
AMNESIA (Memory)	☐	☐	☐
DIZZINESS (Vertigo)	☐	☐	☐
HEADACHES	☐	☐	☐
PARALYSIS	☐	☐	☐
FATIGUE	☐	☐	☐
WEAKNESS	☐	☐	☐
NERVOUSNESS	☐	☐	☐
LOSS OF STRENGTH	☐	☐	☐

RESPIRATORY			
SHALLOW BREATH	☐	☐	☐
COUGH	☐	☐	☐
SPUTUM	☐	☐	☐
SHORT BREATHES	☐	☐	☐
ASTHMA	☐	☐	☐
IRREGULAR BREATHING	☐	☐	☐

Ears, Eyes, Nose & Throat	No	Recent	Past
NOSE BLEEDS	☐	☐	☐
SINUS DRAINAGE	☐	☐	☐
SORE THROAT	☐	☐	☐
DIFFICULTY SWALLOWING	☐	☐	☐
HEARING LOSS	☐	☐	☐
VISION LOSS	☐	☐	☐

GASTROINTESTINAL			
NAUSEA/VOMITTING	☐	☐	☐
CHANGE IN BOWEL HABITS	☐	☐	☐
DISTENTION (Abdominal Swelling)	☐	☐	☐
TARRY STOOLS	☐	☐	☐
BLOODY STOOLS	☐	☐	☐
HEPATITIS	☐	☐	☐

Musculoskeletal			
BACK PAIN	☐	☐	☐
NECK PAIN	☐	☐	☐
LEG PAIN	☐	☐	☐
ARM PAIN	☐	☐	☐
FRACTURE	☐	☐	☐
JOINT SWELLING	☐	☐	☐

Patients Name: ____ Date: ___________________

CARDIOVASCULAR

	No	Recent	Past
CHEST PAIN	☐	☐	☐
ANKLE SWELLING	☐	☐	☐
High Blood Pressure	☐	☐	☐
HEART MURMUR	☐	☐	☐
Irregular Heartbeat	☐	☐	☐
HEART ATTACK	☐	☐	☐
STROKE	☐	☐	☐
Blood Clot in Lung	☐	☐	☐

PROSTHESIS

(do you have any of the following)

	No	Recent	Past
DENTURES	☐	☐	☐
Removable Bridge	☐	☐	☐
ARTIFICIAL EYE	☐	☐	☐
HEARING AID	☐	☐	☐
PACEMAKER	☐	☐	☐
ARTIFICIAL LIMB	☐	☐	☐
BRACE	☐	☐	☐
Internal Metal Clips	☐	☐	☐

Where? ________________________________

REPRODUCTIVE & URINARY SYSTEM

Frequency in urination	☐	☐	☐
Burning on urination	☐	☐	☐
Bloody Urine	☐	☐	☐
Unable to control Bladder	☐	☐	☐
Prostate Problems	☐	☐	☐

Frequent Infections	☐	☐	☐
Diabetes	☐	☐	☐

Do you take insulin? ______________________

Bleeding Disorder	☐	☐	☐
History of free Bleeding	☐	☐	☐

Date of Last Menstrual Period ____________________________

Please use the space below to list any information that has not been mentioned above that you feel would benefit the doctor in his treatment of your case.

____

____

____

SOUTHEAST VASCULAR GROUP

www.endovascular.net

INSURANCE LIABILITY NOTICE

Physician Statement
In many cases, your insurance company will limit payment of a service due to limitations of your policy. If your insurance company does not pay for a service due to a policy limitation, you are financially responsible for the payment of that service. If your insurance company denies payment for any or your entire bill, you will be personally and fully responsible for payment.

Beneficiary Agreement
I understand that in some cases, certain services will be denied payment from my insurance company due to the limitation of my personal policy. In the case that my insurance company denies payment for this service. I understand that I am fully responsible for the payment of this service.

Signature ____ Date ________________

____ Date ________________
Parent or Guardian if patient is under 18 years of age

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Fernando E Kafie, M.D., FACS	Jon C. Allmon, M.D.	Layne R Yonehiro, M.D., FACS

MEDICAL RECORD RELEASE AND INSURANCE ASSIGNMENT

I hereby give any/or all of the above physicians' full authorization for the following:

1) Furnish all information necessary to insurance carriers concerning my illness and treatment.
2) Receive all information necessary from insurance carriers, which may be involved in my in my health care.
3) I hereby assign to the physicians all payments for medical services rendered to myself or My dependants.
4) I understand that I am fully responsible for any amount not covered by insurance.
5) Furnish to any requesting physician who may be involved in my care and any/all medical records.
6) Authorization to receive and/or all medical records and all test results from any physician or other facilities involved in my medical care.

This includes authorization to fax or mail any information to other physicians or other facilities involved in my medical care.

____ __________________

Printed Name Date

____

Signature

BAPTIST OFFICE/NAVARRE
1717 N. "E" Street, Suite 533
Pensacola, FL 32501
Phone: 850-429-0102
Fax: 850-429-0803

SACRED HEART OFFICE
5147 N. 9th Ave., Suite G-21
Pensacola, FL 32504
Phone: 850-969-1491
Fax: 850-969-1443

Consent for Southeast Vascular Group to Release Protected Health Information

I authorized Southeast Vascular Group to release my protected health information for the purpose of treatment, payment, and health care operations. I understand that Southeast Vascular Group will release the minimum necessary amount of protected health information in each case. I acknowledge that I have had the opportunity to review the Privacy Notice. I understand that I can request restrictions to the use of my protected health information in writing. I understand that Southeast Vascular Group is not required to agree to my requested restrictions if it is felt the restriction interferes with my treatment and /or payment of health care operations. I understand that I can revoke this consent in writing should I decide to do so. I understand that Southeast Vascular Group's treatment may be conditional to my signature on this document. I authorize Southeast Vascular Group to release any protected health information necessary to third party payers (such as insurance companies) to assist in the filing of my insurance. I authorize all medical and surgical benefits to be paid directly to Southeast Vascular Group for the treatment performed on me. This assignment of benefits will remain in effect until I revoke it in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges. I authorize Southeast Vascular Group and their staff to leave messages concerning my appointments, lab test results, and test results on my home answering machine should that be necessary.

Signature of patient or personal representative________________________________

Name of patient of personal representative ___________________________________

Date _________________________

SOUTHEAST VASCULAR GROUP

PROTECTED HEALTH INFORMATION STATEMENT

Patient Statement
I have received Southeast Vascular Group, L.P. policies and procedures booklet on how my Protected Health Information will be used and disclosed.

____ Date _______________
Patient Signature

Person(s) Authorized to Receive Protected Health Information
Health information Southeast Vascular Group, L.P. collects or receives about you may be disclosed to the following persons.

Name of person / Relationship / Organization	Phone No.#
Name of person / Relationship / Organization	Phone No.#
Name of person / Relationship / Organization	Phone No. #
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