AVS | ALABAMA VASCULAR SPECIALISTS

Patient Name: _____ DOB: _____/_____/_____

Sex: Male____ Female____ Social Security # _____-_____-_____

Driver's License# _____ Marital Status: M ___ S ___ D ___ W __

Race: ( ) White ( ) Black/African American ( ) Asian ( ) Hispanic ( ) Other

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

Work: _____ Email: _____

Employed? (For insurance purposes, please circle) Yes or No

Pharmacy Name: _____ Pharmacy Location: _____

Referring Physician: _____ Primary Physician: _____

Emergency Contact and person(s) we may release information to:

Name: _____Phone: _____Relation: _____

Name: _____Phone: _____Relation: _____

Primary Insurance: _____ Policy Holder: _____

Member ID/Policy#_____ Group# _____ DOB: _____

Secondary Insurance: _____ Policy Holder: _____

Member ID/Policy#_____ Group#_____ DOB: _____

Tertiary Insurance: _____ Policy Holder: _____

Member ID/Policy#_____ Group# _____DOB: _____

Signature: _____ Date: _____

ALABAMA VASCULAR SPECIALISTS

Are you on dialysis? □ NO □ YES If yes, what days? _____

Dialysis center name: _____

Dialysis phone number: _____ Years on dialysis: _____

Do you smoke? □ NEVER □ FORMER SMOKER □ YES – AMOUNT _____

Do you drink alcohol? □ NO □ YES – AMOUNT PER DAY _____

GENERAL:
□ HIV
□ Hepatitis B
□ Hepatitis C
□ Other: _____

GASTROINTESTINAL:
□ Stomach pains
□ Heart burn
□ Constipation
□ Diarrhea
□ Black or bloody stool

SKIN:
□ Cellulitis & abscess
□ Pressure ulcer
□ Swelling
□ Lymphedema

MUSCULOSKELETAL:
□ Arthritis
□ Fibromyalgia
□ Osteoporosis
□ Back pain

VASCULAR:
□ Abdominal aortic aneurysm
□ Carotid artery disease
□ DVT
□ Leg swelling
□ Peripheral vascular disease
□ Varicose veins

CARDIOVASCULAR:
□ Congestive heart failure
□ High blood pressure
□ Heart attack
□ Irregular heart rhythm

NEUROLOGIC:
□ Alzheimer's disease
□ Multiple sclerosis
□ Neuropathy
□ Parkinson's disease
□ Stroke □ TIA (mini stroke)

HEENT:
□ Headaches
□ Hearing loss
□ Vision loss
□ Vertigo

PULMONARY:
□ Asthma
□ COPD
□ Emphysema
□ Sleep apnea

ENDOCRINE:
□ Diabetes
□ Hypercholesterolemia
□ Hypothyroidism

PAST SURGICAL HISTORY:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

ALLERGIES:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION LIST:

Name of Medication	Dosage	Method (Oral, IV, etc.)	Frequency taken

Please list any **BLOOD THINNERS** that you are **currently** taking:

_____

Thank you for choosing Alabama Vascular Specialists. We are committed to providing our patients with top notch and affordable healthcare. Because you may have questions regarding personal and insurance responsibility for services rendered, we have developed this payment and financial policy. Please read it, ask for clarification if needed, and sign in the space provided.

MEDICAL CONSENT

The undersigned consents to any x-ray examination, laboratory procedure(s) and medical treatment rendered to the patient under the general or special supervision of, or upon the advice of medical provider at Alabama Vascular Specialists.

_____ (Initial)

RELEASE OF INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement to Alabama Vascular Specialists the patient's medical records may be disclosed to any person or corporation (or any agent of such person or corporation) which is or may be liable for all or any portion of changes by Alabama Vascular Specialists, (including but not limited to insurance companies, health care service plans, worker's compensation carriers and employers.)

_____ (Initial)

ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my insurance benefits to Alabama Vascular Specialists. Payment shall not exceed the group's regular charges for treatment. I understand that Alabama Vascular Specialists is an Out of Network provider and are not contracted with my insurance aside from Medicare. I am financially responsible to the medical group for charges not covered by this authorization.

_____ (Initial)

FINANCIAL AGREEMENT

In consideration of the service to be rendered to the patient, the undersigned agrees, whether they sign as patient, agent, or as a financially responsible party, to pay all charges for patient's care to Alabama Vascular Specialists in accordance with the medical groups current rates and terms.

_____ (Initial)

The undersigned certifies that they have read the foregoing, received a copy of the same and accepts all its terms and conditions.

Patient Signature or Patient's Agent or Representative_____
Patient Name (Print)_____
Date_____