Dr. Siddhartha Rao
1000 Crescent Green, Suite 102
Cary, NC 27518

Vascular Solutions of North Carolina

P: 919-897-5999
F: 919-897-5980
www.vascularsolutions.org

New Patient History Form

Demographic Information

Today's Date: _____/_____/_____ Chart Number (to be filled in by practice): _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____/_____/_____ Age: _____ Social Security Number: _____-_____-_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ White ☐ Hispanic ☐ African-American ☐ Asian ☐ Native American ☐ Other ☐ Decline

Preferred Language: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Primary Care Doctor: _____ Referring Doctor: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

Preferred Pharmacy: _____

Address: _____

Emergency Contact: _____ Relationship: _____

Phone Number: (_____)_____-_____

Insurance Information

Name of Insurance: _____ Policy Number: _____

Group Number: _____

Name of Policy Holder: _____ Relationship to Patient: _____

First Initial: _____ Last Name: _____

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Medication Record

Today's Date: _____/_____/_____

Patient Name: _____
(First) (M.I) (Last)

Height: _____ Weight: _____ Date of Birth: _____/_____/_____ Age: _____

Medication (Including Over the Counter & Supplements)	**Frequency**

First Initial: _____ Last Name: _____

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Medical History

Allergies: Drug Allergies? ☐ Yes ☐ No Latex Allergy? ☐ Yes ☐ No Contrast Allergy? ☐ Yes ☐ No Shellfish Allergy? ☐ Yes ☐ No

Please list all allergies: _____

_____

_____.

Social History

Have you ever used tobacco products? ☐ Yes ☐ No
If yes, do you still currently use tobacco products? ☐ Yes ☐ No
If yes, amount per day? _____ Years of use? _____
If no, age quit? _____

Do you regularly drink alcohol? ☐ Rarely ☐ Socially ☐ Daily

Do you use illicit drugs (including marijuana)? ☐ Yes ☐ No
Type of Drugs Used: _____

What is your current or past occupation? _____

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Past Medical History

Do you now, or have you ever, had any of the following:

Cardiovascular	□ Deep Vein Thrombosis	□ High Blood Pressure	**Hematology**
□ Heart Attack	□ Pulmonary Embolism	Other:	□ Leukemia
□ Heart Stents	**Gastrointestinal**	**Pulmonary**	□ Abnormal Bleeding
□ Coronary Bypass Surgery	□ Acid Reflux	□ COPD/Emphysema	□ Clotting Disorder
□ Hypertension	□ Hiatal Hernia	□ Asthma	□ Anemia/Transfusion
□ Leg Stents/Bypass	□ Stomach or peptic ulcer	□ Pneumonia	**Neuro**
□ Congestive Heart Failure	□ Polyps	**Renal/GU**	□ Seizures
□ Pacemaker/Defibrillator	□ Liver Disease/Cirrhosis	□ BPH	□ Dementia
□ Palpitations	□ Hepatitis	□ Kidney Disease	□ Parkinson's
□ Atrial Fibrillation	□ Pancreatitis	□ Dialysis	□ Anxiety/Depression
□ Carotid Artery Disease	□ Colitis	□ Kidney Stones	□ Psychiatric Care
□ Stroke/TIA (mini-stroke)	□ Gall Bladder Surgery	**Musculoskeletal**	**Misc.**
□ Carotid Surgery/Stent	**Cancer**	□ Back Pain/Surgery	□ Sleep Apnea
□ Aneurysm	Type:	□ Arthritis	□ HIV/AIDS
□ Varicose Veins	**General**	□ Joint Replacement	□ MRSA
□ Vein Stripping/Ablation	□ Diabetes	□ Gout	□ Organ Transplant

Please list any past surgeries, including year they occurred:_____

_____.

Family History

□ Family History Unknown

Have any of the relatives listed below had a heart attack before 65 or limb amputation?

	Age	Yes or No	If Deceased, Age of Death?	Cause of Death
Father				
Mother				
Siblings				
Children				

Extended family medical problems past and present:

Maternal Relatives: _____

_____

Paternal Relatives: _____

_____

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Review of Recent Symptoms

In the past month, have you had any of the following problems?

General	□ Constipation	□ Nighttime Urination	□ C Diff
□ Fever	□ Diarrhea	□ Blood in Urine	**Women Only**
□ Unexplained Weight Gain or Loss	□ Blood in Stool	**Eyes**	□ Irregular/Abnormal Menstrual Bleeding
□ Fatigue	□ Black Stool	□ Floaters/Cataracts	□ Breast Lumps/Masses
□ Weakness	**Musculoskeletal**	□ Blurred/Double Vision	□ Possibility of Pregnancy
□ Night Sweats	□ Joint Pain	□ Loss of Vision	□ Post-Menopausal Bleeding
Cardiac	□ Joint Swelling	□ Pain	**Men Only**
□ Chest Pain	□ Back Pain	**Ears**	□ Erectile Dysfunction
□ Palpitations	□ Muscle Weakness	□ Ringing in Ears	
□ Shortness of Breath	□ Muscle Aches	□ Loss of Hearing	
□ Swollen Legs or Feet	**Neuro**	**Nose**	
Vascular	□ Headaches	□ Bleeding	
□ Varicose Veins	□ Dizziness	□ Sinus Problems	
□ Leg Pain/Fatigue	□ Passing Out	**Throat**	
□ Leg Cramps	□ Numbness or Tingling	□ Sore Throat	
□ Leg Aching	□ Memory Loss	□ Hoarseness	
Pulmonary	□ Seizures	□ Difficulty Swallowing	
□ Cough/Blood	□ Stroke	□ Pain in Jaw	
□ Wheezing	□ Loss of Balance	**Sleep**	
Skin	□ Trouble Speaking	□ Snoring	
□ Non-Healing Sores	**Hematology**	□ Insomnia	
□ Hair Loss	□ Anemia/Transfusion	□ Daytime Sleepiness	
□ Redness	□ Clots	**Psychiatric**	
□ Rashes	□ Unusual Bleeding/Bruising	□ Depression	
□ Itching	**Lymph**	□ Anxiety	
Gastrointestinal	□ Enlarged Lymph Nodes	□ Hallucinations	
□ Nausea	**Renal/GU**	**Infections**	
□ Heartburn	□ Frequent Urination	□ HIV/AIDS	
□ Stomach Pain	□ Painful Urination	□ MRSA	
□ Vomiting	□ Difficulty/Hesitation Urinating	□ Hepatitis B/C	

Please list any additional medical conditions that are not previously listed: _____

_____.

First Initial: _____ Last Name: _____

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Screening Questions

To help us better serve your current and future healthcare needs, we need to know if you exhibit any possible risk factors for conditions we specialize in. Please check the boxes below that demonstrate possible risk factors you may exhibit. These risk factors in no way determine a diagnosis, they simply help us become better acquainted with your health and history.

Cardiovascular Disease

- □ Over age 65
- □ Diabetes Mellitus
- □ Smoking (Current or Past)
- □ Hypertension
- □ Hyperlipidemia

Venous Insufficiency

- □ Female Gender
- □ Family History of Venous Insufficiency or Deep Vein Thrombosis
- □ History of Cancer
- □ Recent Immobility
- □ History of Lower Back/Complex Abdominal/Pelvic Surgeries
- □ Radiation to the Abdomen/Pelvis

Abdominal Aortic Aneurysm

- □ Former or Current Smoker
- □ Over age 65
- □ Family history of Abdominal Aortic Aneurysm

GAE (STAFF: Reference WOMAC Questionnaire, if necessary)

- □ Over age 50
- □ BMI > 23
- □ History of knee injury
- □ Moderate to severe pain, stiffness, swelling, or deformity of the knee
- □ Osteoarthritis based on x-ray
- □ Resistant or failed medical treatment regarding knee pain
- □ Frequent high impact physical activity

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HIPPA Disclosure

This HIPPA form us designed to provide privacy standard to protect patient's medical records and other health information provided to health plans, doctors, hospitals, and other health care providers.
I understand that as part of the delivery of my health care, Vascular Solutions of North Carolina originates and maintains medical records describing my health history, symptoms, examinations, test results, diagnoses, treatment and 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 healthcare professionals who contribute to my care.
- A tool for routine healthcare operations such as assessing quality and ensuring the continued competence of health care professionals involved in my care.
- I have been provided with a Notice of Information Practices that provides a more complete description of the uses and disclosures of my health information.
- I understand that Vascular Solutions of North Carolina reserves the right to change this notice and their practices as needed and will make a reasonable attempt to inform me.
- I understand that I have the right to request restrictions in the use or disclosure of my health information for treatment of healthcare operations and that Vascular Solutions of North Carolina is not required to agree to the restrictions requested.
- I understand that I may revoke this acknowledgement in writing except to the extent that Vascular Solutions of North Carolina has already taken action on it.

Authorization to Use and Disclose Protected Health Information

Please note: If the patient is physically or mentally unable to sign, a representative may sign on the patient's behalf. In this event, the signature line must indicate the patients name, followed by the representatives name, address and relationship to the patient, along with the reason the patient cannot sign for themselves. The authorization is effective indefinitely unless patient or patients representative revoke this arrangement.

With my consent, Vascular Solutions of North Carolina may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and health care operations. Please refer to Vascular Solutions of North Carolinas Note of Privacy Practices for a more complete description of such use and disclosure. I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Vascular Solutions of North Carolina reserves the right to revise its Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, Vascular Solutions of North Carolina.
As a patient you have a right to inspect a copy, amend, request a restriction, or revoke a prior restriction on the use and disclosure of your Protected Health Information. You may also request a copy of an accounting of disclosure, which will detail all disclosures made for reasons other than treatment, payment, or heath care operation purposes. I hereby am consenting Vascular Solutions of North Carolina to use and disclose my PHI for typical healthcare operations. I am also acknowledging that I have been presented with the Vascular Solutions of North Carolina Notice of Privacy Practices. If I do not sign this consent, Vascular Solutions may decline to provide treatment to me.

Consent to Medical Care

I hereby agree and give consent for Vascular Solutions of North Carolina to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical condition.

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DNR Policy

It is the policy of Vascular Solutions of North Carolina to always preform CPR when indicated. If you have a DNR order in place and you wish to have this DNR order honored, you will need to have your procedure scheduled at a different facility.

Release of Information for Billing Purposes

I hereby authorize the designated physician to release any information acquired during my treatment to my insurance company for completion of claims, in consideration of the medical services to be rendered. I assign all payments made from my insurance provider(s) to Vascular Solutions of North Carolina, and not myself, for all services provided. If these benefits or payments are sent to me in error, I recognize these benefits or payments are owed to Vascular Solutions of North Carolina and I will immediately forward the benefit payment to the practice. I agree to pay for all charges not paid by insurance. If applicable, I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize Vascular Solutions of North Carolina to use my information for a range of purposes including but not limited to: insurance/payment, eligibility/benefit verification, billing and collecting money due from payor or their agents including insurance companies, managed care entities, certification, quality of care assessment and improvement activities, evaluation of the performance or qualifications of physicians and health care workers, conducting healthcare staff training and educational programs, ensuring compliance with legal, regulatory and accreditation requirements, and public health activities. I authorize Vascular Solutions of North Carolina to utilize or release my health information. whether written, verbal, or electronic, to such employees, billing companies, agents or third parties necessary for these purposes. I certify that I have read the above or had it explained to me, and I agree to all terms.

Policy Regarding Financial Responsibility

We have contracts with many insurance companies and we will bill them as a service to you. We will let you know in advance if we are not in network with your policy. If you wish to be seen at Vascular Solutions of North Carolina, you are responsible for payment of co-pays and/or deductible charges at the time of service. If you are uninsured, or we are not in network with your insurance policy, we are happy to provide services to you at a self-pay rate. As the responsible party, you are financially responsible if your insurance company declines to pay for any reason. If you are in need of a payment plan, you are expected to reach out to our financial department before your procedure to make arrangements. We accept payment in the form of credit card, cash or check. Any checks returned to us due to insufficient funds, or any other reason, will result in a fee of $25.00 each.

The person signing on behalf of the patient as the Responsible Party must:

- Inform Vascular Solutions of North Carolina of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each visit and verify at each visit that it is current.
- Pay any required co-pay/deductible amounts at the time of service, then agree to pay any additional amounts due within 30 days of receiving a statement from our office.

I have read this financial policy and understand that I am responsible for payment of medical services provided by Vascular Solutions of North Carolina, and hereby assume and guarantee payment of all expenses incurred during my visit. Should legal action be required to secure payment, I agree to pay the legal expenses incurred by this office.

_____ _____/_____/_____

Patient Signature Date

First Initial: _____ Last Name: _____

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Authorization for Release of Medical Records

Patient Name: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____-_____

Address of Physicians Office: _____

City: _____ State: _____ Zip: _____

Phone Number of Physicians Office: (_____) _____-_____

I REQUEST MY MEDICAL RECORDS TO BE RELEASED TO:
VASCULAR SOLUTIONS OF NORTH CAROLINA
1000 CRESCENT GREEN, SUITE 102
CARY, NC 27518
PHONE: (919) 897- 5999
FAX: (919) 897- 5980

By my signature, I authorize release of my medical records.

_____ _____/_____/_____
Patient Signature Date

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Patient Signed Authorization to use and Disclose PHI to Specific Individuals

I have read and understand the information regarding the use and disclosure of Patient Health Information. I have received a copy of this form and I am the patient or individual authorized to act on behalf of the patient.

Chart Number (to be filled in by practice): _____

Patient Name: _____

Address: _____

Telephone: Home:(_____)_____-_____ Cell: (_____)_____-_____

Patient Authorization to Release Information

I, (PRINTED NAME) _____, herby authorize Vascular Solutions of North Carolina to release the following information to the individuals listed below:

- □ Consult Notes
- □ Office Visits
- □ Procedure Notes
- □ Imaging Reports
- □ Medical Records
- □ Other: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____

Printed Name: _____

Date: _____/_____/_____