Vascular Solutions
1000 Crescent Green, Suite 102
Cary, NC 27518

Phone: (919) 897-5999
Fax: (919) 897-5980
vascularsolutions.org

New Patient Intake Form

Today's Date: / /				Chart Number:	
Name: First		Middle Initial		Last	
Date of Birth: / /				**Age:**	
Sex: Male	Female	Intersex		Social:	
Race: White	Hispanic	African American	Asian	Native American	Other
Email:					
Street Address:					
City:		**State:**		**Zip:**	
Home Phone: ( )			**Cell Phone:** ( )		

Primary Care Doctor:	**Referring Doctor:**
Address:	Address:
Phone: ( )	Phone: ( )

Preferred Pharmacy:	
Address:	

Emergency Contact:	**Relationship:**
Phone: ( )	

Name of Insurance:	**Policy Number:**
Group Number:	
Name of Policy Holder:	Relationship:

Name of Secondary:	Policy Number:
Group Number:	
Name of Policy Holder:	Relationship:

Initials: _____

Dr. Siddhartha Rao
Vascular Solutions

P: (919) 897-5999

New Patient History Form

Name:	Date:
Date of Birth:	Age:
Reason you are here:	

Allergies

Allergy	Yes	No	Please list all allergies below
Drug	☐	☐	
Latex	☐	☐	
Contrast	☐	☐	
Shellfish	☐	☐	

Screening Questions

Please check any conditions you have had. Each checkbox represents a possible risk factor for each section and does not determine a diagnosis.

Cardiovascular Disease

- ☐ Diabetes mellitus
- ☐ Chronic kidney disease
- ☐ Former or current smoker
- ☐ High blood pressure
- ☐ High cholesterol

Genicular Artery Embolization

- ☐ Overweight or obese BMI
- ☐ History of knee injury
- ☐ Moderate to severe knee pain, stiffness, swelling, or deformity
- ☐ Osteoarthritis based on x-ray
- ☐ Resistant or failed medical treatment for knee pain
- ☐ High-impact physical activity

Venous Insufficiency

- ☐ Family history of varicose veins or swollen legs
- ☐ Personal or family history of a blood clot in a deep vein
- ☐ Personal history of cancer
- ☐ Recent decrease in mobility
- ☐ Complex lower back, abdominal, or pelvic surgeries
- ☐ Multiple pregnancies
- ☐ Radiation to abdomen/pelvis

Abdominal Aortic Aneurysm

- ☐ Former or current smoker
- ☐ Family history of abdominal aortic aneurysm

Do you have **wounds, calluses, or corns** on your legs or feet? ☐ Yes ☐ No

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Medical History

Cardiovascular	Pulmonary	Neurological
☐ Heart disease	☐ COPD/Emphysema	☐ Dementia
☐ Heart attack	☐ Asthma	☐ Anxiety/Depression
☐ Congestive heart failure	☐ Pneumonia	☐ Psychiatric care
☐ Palpitations	**Gastrointestinal**	**General**
☐ Atrial fibrillation	☐ Acid reflux	☐ Sleep apnea
☐ Carotid artery disease	☐ Hiatal hernia	☐ Kidney disease/dialysis
☐ Stroke	☐ Stomach or peptic ulcer	☐ Thyroid disease
☐ TIA (mini-stroke)	☐ Polyps	☐ Liver disease
☐ Aneurysm	**Musculoskeletal**	☐ Cancer: _____
☐ Varicose veins	☐ Back pain	☐ Bleeding disorder
☐ Blood clot in legs	☐ Arthritis	☐ HIV disease/exposure
☐ Blood clot in lungs	☐ Gout	☐ Hepatitis (A, B, or C)

☐ Other:

Surgical History

Surgery/Procedure	Year	Surgery/Procedure	Year
☐ Coronary bypass		☐ Carotid surgery/stent	
☐ Cardiac catheter		☐ Pacemaker/defibrillator	
☐ Angioplasty		☐ Hysterectomy	
☐ Heart stent		☐ Gall bladder surgery	
☐ Leg stent		☐ Joint replacement: _____	
☐ Vein stripping/ablation		☐ Organ transplant: _____	

☐ Other:

Social History

	Yes	No
Have you ever used tobacco?	☐	☐
Do you still use tobacco?	☐	☐
Type: _____		
Amount: _____		
Year or age quit: _____		

	Yes	No
Do you drink alcohol?	☐	☐
Frequency: _____		
Do you use illicit drugs?	☐	☐
Type of drug: _____ (including marijuana)		

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

Work Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Disability

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Medication Record

Please list or attach a copy of all medications you take.
Include over the counter & supplements.

Medication	Dose	Frequency

Family History

☐ Family history unknown

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

	Age	Heart attack	Amputation	If deceased, age and cause of death
Father		☐	☐	
Mother		☐	☐	
Siblings		☐	☐	
Children		☐	☐	

Extended family medical problems past and present

Maternal relatives:
Paternal relatives:

Initials: _____

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

General
- ☐ Fever
- ☐ Unexplained weight gain
- ☐ Unexplained weight loss
- ☐ Fatigue
- ☐ Weakness
- ☐ Night sweats

Cardiac
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Swollen legs or feet

Vascular
- ☐ Leg pain/fatigue
- ☐ Leg cramps
- ☐ Leg aching

Pulmonary
- ☐ Cough/blood
- ☐ Wheezing

Skin
- ☐ Non-healing sores
- ☐ Hair loss
- ☐ Redness
- ☐ Rashes
- ☐ Itching

Lymph
- ☐ Enlarged lymph nodes

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Hallucinations

Gastrointestinal
- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Black stool

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Muscle aches

Neurological
- ☐ Headaches
- ☐ Dizziness
- ☐ Passing out
- ☐ Numbness or tingling
- ☐ Memory loss
- ☐ Seizures
- ☐ Stroke
- ☐ Loss of balance
- ☐ Trouble speaking

Ear, Nose, and Throat
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Pain in jaw

Hematology
- ☐ Anemia/transfusion
- ☐ Clots
- ☐ Unusual bleeding
- ☐ Bruising

Renal
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Difficulty urinating
- ☐ Nighttime urination
- ☐ Blood in urine

Eyes
- ☐ Floaters/cataracts
- ☐ Blurred/double vision
- ☐ Loss of vision
- ☐ Pain

Infections
- ☐ HIV/AIDS
- ☐ MRSA
- ☐ Hepatitis B/C
- ☐ C. diff

Sleep
- ☐ Snoring
- ☐ Insomnia
- ☐ Daytime sleepiness

Women only
- ☐ Irregular menstruation
- ☐ Abnormal menstruation
- ☐ Breast lumps/masses
- ☐ Possibility of pregnancy
- ☐ Postmenopausal bleeding

Men only
- ☐ Erectile Dysfunction

Other:

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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.

Initials: _____

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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.

Signature: _____ **Date:** _____

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Authorization for Release of Medical Records

Patient Information

Name:		
Date of Birth: / /		Social Security:
Street Address:		
City:	State:	Zip:
Phone: ( )		

Physician's Office Information

Name:		
Address:		
City:	State:	Zip:
Phone: ( )		

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.

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.

Patient Name:	Chart Number:
Date of Birth:	

Patient Authorization to Release Information

I, (PRINTED NAME) _____ hereby 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:
Name:	Relationship:
Name:	Relationship:

Signature: _____ **Date:** _____