



Patient Name: \_\_\_\_\_ Patient D.O.B: \_\_\_\_\_

Have you had any of the following?

<input checked="" type="checkbox"/>	DISEASE	COMMENTS
	Seizure Disease?	How often? _____
	Thyroid Disease	___ Hypothyroidism ___ Hyperthyroidism ___ Goiter ___
	Pulmonary Disease	___ Asthma ___ COPD ___ Emphysema ___ TB ___ Pneumonia
	Stroke	___ TIA (mini stroke) ___ Sudden blindness ___ Weakness in arms/legs ___ Carotid stenosis ___ Bruit
	GI Disease	___ Ulcers ___ Hiatal Hernia ___ GERD ___ Diverticulitis ___ Crohn's ___ Gallstones
	Diabetes	___ Insulin dependent ___ Non-insulin ___ Controlled by diet
	Kidney Disease	___ ESRD ___ Dialysis
	Blood Disease	___ Bleeding Disorder ___ Clotting Disorder
	Liver Disease	___ Hepatitis ___ Cirrhosis
	Cancer	___ Type:
	Vascular Disease	___ Peripheral Vascular Disease ___ Angioplasty/Stent ___ Leg/Foot Ulceration ___ Claudication ___ Decreased walking distance ___ Foot pain at rest ___ Foot pain during exercise ___ Extreme discoloration changes ___ Loss of limb ___ Aneurysm ___ Diabetic neuropathy ___ Temperature changes
	Heart Disease	___ Heart Attack/ MI ___ Angina ___ Hypertension ___ CHF ___ Coronary angioplasty/stent/PTCA ___ Open heart surgery/CABG ___ AFIB ___ IRRG HR ___ Murmur ___ Rheumatic heart disease ___ Valve disease/repair/replacement ___ Coronary heart disease

### FAMILY HISTORY

Please check the boxes pertaining to your family history.

	FATHER	MOTHER	BROTHERS	SISTERS
Living				
Deceased Cause/death				
Age of death				
Cancer				
Diabetes				
Heart Attack				
Stroke				
PVD				
COPD				
TB				
Other Problems:				



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 Melbourne, FL 32901

Phone : (321)751-2707  
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**VENOUS HISTORY**

Today's Date: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Are you pregnant, nursing or planning a pregnancy in the near future?      Yes      No

**Check box in front of ALL that apply:**

**SYMPTOMS:**

<input type="checkbox"/>	Aches	<input type="checkbox"/>	Heavy/full feeling	<input type="checkbox"/>	Symptoms interfere w/ activities of daily living
<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	Bleed/ Hemorrhage	<input type="checkbox"/>	Leg Restlessness
<input type="checkbox"/>	Swelling	<input type="checkbox"/>	Cramping	<input type="checkbox"/>	Pelvic Symptoms
<input type="checkbox"/>	Muscle fatigue	<input type="checkbox"/>	Itch	<input type="checkbox"/>	Ulceration <u>    </u> Healed <u>    </u> Non-healed, How long present? <u>    </u>
<input type="checkbox"/>	Pain	<input type="checkbox"/>	Burning	<input type="checkbox"/>	I am NOT able to walk a mile without symptoms

**WORSE WHEN:**

<input type="checkbox"/>	Standing	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	Walking/exercise
<input type="checkbox"/>	Pre-menstrual	<input type="checkbox"/>	Night time	<input type="checkbox"/>	Other: _____
Worsening of symptoms with pregnancy; Date of last pregnancy: _____					

**CONSERVATIVE THERAPY:**

<input type="checkbox"/>	Leg Elevation	<input type="checkbox"/>	Elastic compression garment use; Attempted more than 3-6 months.
<input type="checkbox"/>	Exercise	<input type="checkbox"/>	Compression garment use Helpful
<input type="checkbox"/>	Heat	<input type="checkbox"/>	Compression garment use Failure; Reason: _____
<input type="checkbox"/>	Medications: _____	<input type="checkbox"/>	Other: _____

**PREVIOUS INVASIVE TREATMENT:**

<input type="checkbox"/>	SURGERY:	<input type="checkbox"/>	Stripped-right leg	<input type="checkbox"/>	Stripped-left leg	Date:	<input type="checkbox"/>	Complications?	Y	N
<input type="checkbox"/>	SURGERY:	<input type="checkbox"/>	Ligation-right leg	<input type="checkbox"/>	Ligation-left leg	Date:	<input type="checkbox"/>	Complications?	Y	N
<input type="checkbox"/>	INJECTIONS:	<input type="checkbox"/>	Right leg	<input type="checkbox"/>	Left leg	Date:	<input type="checkbox"/>	Complications?	Y	N
<input type="checkbox"/>	LASER:	<input type="checkbox"/>	Right leg	<input type="checkbox"/>	Left leg	Date:	<input type="checkbox"/>	Complications?	Y	N

**COMMENTS:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### CANCELLATION POLICY

Phone:(321)751-2707  
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#### OFFICE VISITS, VASCULAR LAB TESTS, SURGICAL PROCEDURES

To better serve all of our patients, it is extremely important that when you schedule your visits, *tests*, or surgical procedures that you have thoroughly checked your personal calendar to make sure the time is ideal for you. Cancelling and rescheduling causes other patients to wait longer and delay treatment times.

#### UNPLANNED CANCELLATIONS AND NO SHOW POLICY

- Each *Office visit* will be rescheduled one time as a courtesy. After that time, a **\$50 fee** will be charged to your personal account and not billed to insurance for every cancellation less than **24 hours** of the scheduled appointment or a No Show appointment.
- Each *Vascular lab test* will be rescheduled **one time** as a courtesy. After that time, a **\$150 fee** will be charged to your personal account and not billed to insurance for every cancellation less than **24 hours** of the scheduled appointment or a No Show appointment.
- *Surgical procedures in the office* must be canceled or rescheduled **48 hours** in advance. Failure to do so will result in a **\$200 fee** charged to your personal account and not billed to insurance.
- *Surgical procedures in the Hospital* **cannot** be rescheduled. If you must cancel, it will need to be within **72 hours** to release the time to other hospital patients. Failure to do so, will result in a **\$250 fee** charged to your personal account and not billed to insurance.
- *Vein/MSA procedures in the office* must be canceled or rescheduled **48 hours** in advance. Failure to do so will result in a **\$100 fee** charged to your personal account and not billed to insurance
- After 3 cancellations with late notices or 3 No Show appointments, the patient will be required to speak with the Practice Administrator before rescheduling.

Thank you, Space Coast Vascular Staff

I have read, understand and agree to the cancellation, no show and financial policies of Space Coast Vascular.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



# New Patient Registration

## Patient Information

### Patient Name

First MI Last

DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Marital Status \_\_\_\_\_  MALE  FEMALE

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Work Phone \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Name of Spouse \_\_\_\_\_

Address: \_\_\_\_\_

Check if same as patient's address

### Race

- American Indian or Alaska Native  Asian
- Native Hawaiian  Black or African American  White
- Other Pacific Islander  Prefer not to answer

### Ethnicity

- Hispanic/Latino  Non-Hispanic/Latino
- Prefer not to answer

### Preferred Language

- English  Spanish  French  Indian (includes Hindu & Tamil)  Other \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_

Location \_\_\_\_\_

Family Doctor \_\_\_\_\_

Phone \_\_\_\_\_

## Insurance Information

Primary Insurance Co \_\_\_\_\_

Policy #: \_\_\_\_\_

*Policy holder information, if not same as patient:*

Name \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Secondary Insurance Co \_\_\_\_\_

Policy #: \_\_\_\_\_

*Policy holder information, if not same as patient:*

Name \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

## Complete below if patient is a minor

Father's Name (or Guardian) \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Work Phone \_\_\_\_\_

Address: \_\_\_\_\_

Check if same as patient's address

Employer \_\_\_\_\_

Mother's Name (or Guardian) \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Work Phone \_\_\_\_\_

Address: \_\_\_\_\_

Check if same as patient's address

Employer \_\_\_\_\_



# New Patient Registration

## HIPAA Release

**Patient Name**

\_\_\_\_\_  
First MI Last

**Emergency Contact:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone #

Do you have a Living Will?  Yes  No  
 Do you have an Advance Directive?  Yes  No  
*If you answered yes to either, please provide us a copy.*

**I authorize Medical Associates of Brevard LLC to discuss my healthcare information with the below:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone #

**Preferred appointment reminder notification:**

- Home Phone  Cell  Cell Text  Work phone
- Mail  E-Mail  None
- With the person(s) authorized above

**Preferred medical information notification:**

***I authorize Medical Associates of Brevard LLC to leave a detailed message which may contain personal health information via:***

- Home Phone  Cell  Cell Text  Work phone
- Mail  E-Mail  None
- With the person(s) authorized above

**Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.**

***Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.***



## Annual Updated Patient Registration

### NOTICE OF MEDICAL / FINANCIAL RECORDS REQUEST FEES ACKNOWLEDGEMENT

Please be advised of our policies and fee schedule for providing copies of medical records or financial statements of account. Fees are calculated in compliance with Florida Statutes, Title XXIX, Chapter 395, § 3025] and federal HIPAA regulations.

#### **TYPE & FEE:**

**Paper copies (to patient/individual)** \$1.00 per page for the first 25 pages, and \$0.25 for each additional page

**Paper copies (to third parties/attorneys)** \$1.00 per page (max allowable rate)

**Records to another healthcare provider for continuation of care** No Charge

**Medical Record Affidavits** \$10.00 per affidavit completed

**Forms (FMLA, Disability, etc.)** \$25.00 for one page; \$35.00 for multiple pages

**Postage/Shipping** cost will vary depending on weight and postage at time of shipping

#### **TERMS:**

\*\*Payment is required in full before records will be released. We accept: Cash, credit card and debit cards.

\*\*Requests are typically processed within 10-15 business days of receiving a signed authorization and payment.

\*\*These fees will also have an additional charge for the actual cost of postage for mailing records.

#### **ACKNOWLEDGEMENT:**

By signing this form, I acknowledge that I have been informed of this fee schedule and agree to be financially responsible for all applicable charges.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date