SOUTH VALLEY VASCULAR

BASS Medical Group

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Full Name of Patient: _____
First Middle Last

Home Address: _____
City Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____

Date of Birth: _____ Age: ____ Male / Female Marital Status: Married____ Single____ Other_____

Race: _____ Language: _____ Ethnicity: _____

Social Security Number: _____ Drivers License Number: _____

How did you hear about us? _____

Primary Care Physician: _____ Referred By Dr. _____

INSURED RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____ Relation to Patient: _____

Address: _____ Phone Number: _____

Employer: _____ Responsible Party SS #: _____

Drivers License Number: _____ Date of Birth: _____

PRIMARY INSURANCE

Insurance Name: _____ ID # _____

SECONDARY INSURANCE

Insurance Name: _____ ID # _____

EMERGENCY CONTACT

Name of Nearest/Relative (Not living with you)

Name: _____ Phone: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by insurance.

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT

I directly assign all medical/surgical benefit to South Valley Vascular Associates and understand that I am financially responsible to all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I further agree that a photocopy to this agreement shall be valid as the original.

PATIENT SIGNATURE: _____ **DATE:** _____

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Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____

What is the name of the Physician who referred you? : _____

What is your Primary Care Physicians Name? : _____

Who is your Podiatrist Doctor? : Dr. _____

Dialysis Name: **Days:** **Time :** am/pm **Nephrologists Name:**

Risk Factors: Do You Have Or Have Ever Had Any Of The Following:

☐ High Cholesterol

☐ Aortic Aneurysm	☐ High Blood Pressure	☐ Heart Disease
☐ Irregular Heartbeat	☐ Stroke	☐ Clotting Disease
☐ Diabetes	☐ Pacemaker	☐ Congestive Heart Failure
☐ Kidney Disease	☐ Lung Disease	☐ Support Hose

Family History of Vascular Disease:

☐ Heart Disease	☐ Varicose Veins	☐ Aortic Aneurysms
☐ Diabetes		

Other medical problems: _____

How far can you walk comfortably? : _____

Please List All Past Surgeries:

_____

_____

_____

_____

_____

Allergies to food/shellfish: _____ **Allergies to medicine:** _____

Allergies to tape: **Yes** **No** **Allergies to latex:** **Yes** **No**

Pharmacy : _____ **Location:** _____

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Please List All Medications You Presently Take:

_____ _____

_____ _____

_____ _____

Non-prescription Drugs: _____

_____

Social History:

Occupation: _____

With whom do you live: _____

Frequency of alcohol consumption: ☐ Heavy ☐ Occasional ☐ None

Smoking consumption: ☐ Heavy ☐ Occasional ☐ None

Packs per day: _____

Are You Currently Experiencing Any Of The Following? : (Please check all that apply)

GENERAL	CARDIOVASCULAR	Indigestion
Fever	Chest Pain	Hepatitis
Chills	Palpitations	Jaundice
Weight Loss	Shortness Of Breath	Anemia
Glasses	Leg Swelling	Bruising
Blurred Vision	Heart Murmur	Rash
Eye Pain	Irregular Heart Beat	NEURO
Loss Of Hearing	RESPIRATORY	Seizures
Ringing In Ears	Cough	Memory Loss
Nose Bleeds	Wheezing	Headache
Sinusitis	OTHER	Dizziness
Dentures	Nausea	Fainting
Difficult To Swallow	Vomiting	Numbness
Bleeding Gums	Diarrhea/Constipation	Weakness
	Thyroid Problems	
	Kidney Stones	
	Urinary Problems	
	Blood In The Urine	