

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

**SAVANNAH VASCULAR AND CARDIAC INSTITUTE  
PATIENT INFORMATION**

To All Patients: Payment is expected at the time of service. Please indicate your payment preference:  
\_\_\_ Cash \_\_\_ Check \_\_\_ Credit Card

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**Please Print Clearly:**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Marital Status \_\_\_ Married \_\_\_ Single Sex \_\_\_ Male \_\_\_ Female Race \_\_\_\_\_ SSN \_\_\_\_\_  
Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Address \_\_\_\_\_  
Referred by \_\_\_ Self \_\_\_ Family/Friend (Name) \_\_\_\_\_ Dr (Name) \_\_\_\_\_

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**Policyholder Information:**

Policyholder Name: \_\_\_\_\_ Relationship to Responsible Party \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ DOB: \_\_\_\_\_ SSN \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

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**If patient is a dependent/minor, please complete the following:**

Leal Guardian/Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ SSN \_\_\_\_\_

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**PRIMARY** Insurance Company \_\_\_\_\_ Insurance ID# \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Group# \_\_\_\_\_ Insured's Name \_\_\_\_\_  
Insured Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Sex \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Employer Name \_\_\_\_\_ Co-Pay Amount \_\_\_\_\_  
Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_

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**SECONDARY** Insurance Company \_\_\_\_\_ Insurance ID# \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Group# \_\_\_\_\_ Insured's Name \_\_\_\_\_  
Insured Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Sex \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Employer Name \_\_\_\_\_ Co-Pay Amount \_\_\_\_\_  
Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_

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**WORKER'S COMPENSATION** Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Group# \_\_\_\_\_ Insured's Name \_\_\_\_\_  
Insured Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Sex \_\_\_\_\_  
Employer Name \_\_\_\_\_ Co-Pay Amount \_\_\_\_\_  
Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_

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Person who does not live with you to contact in emergency \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_



**PHYSICIAN PRACTICE FINANCIAL POLICY AND RELEASE OF INFORMATION**

The following statement of our Financial Policy for services provided within our office and do not apply to any testing or diagnostic procedure performed outside of this physician practice. We require you to read and sign this document prior to treatment at this facility.

**PATIENT RESPONSIBILITY**

All professional services rendered are charged to the patient and are due at the time of service. As a courtesy this practice will file your claim with your insurance carrier; however the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. Any co-payments or deductible amounts not satisfied with your carrier are due at the time of service.

Initial \_\_\_\_\_

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit while others pay only a percentage of the costs. Surgical procedures, labs and other outpatient procedures may have a higher co-payment or fall under the deductible. It is your (the patient) responsibility to understand your insurance coverage.

Initial \_\_\_\_\_

When you receive a statement from the Savannah Vascular and Cardiac Institute, you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, you are to contact a billing representative at the phone number noted on the statement. Do not ignore the bill as it may result in turning the balance to an outside collection agency for recovery.

Initial \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT AND TO RELASE INFORMATION**

The signature below serves as authorization for medical treatment by the physician, physician's assistant, Nurse Practitioner, or nurse for the named patient. It also provides authorization for Savannah Vascular and Cardiac Institute to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator, and/or other health benefit payer representatives in order to process health care claims incurred at this office or for utilization review or quality assurance. This authorization also serves as permission to obtain a copy of your complete medical record from other physician practices or medical facilities. A copy of this authorization may be used in place of the original in obtaining medical records. I understand that I may withdraw this authorization to release medical information at any time, communicated to the practice either in writing or verbally, followed by a written withdrawal.

Initial \_\_\_\_\_

I understand that I am financially responsible to the Savannah Vascular and Cardiac Institute for any balance not covered by my insurance carrier.

**ASSIGNMENT OF BENEFITS**

I hereby assign and authorize my insurance benefits to be paid directly to Savannah Vascular and Cardiac Institute

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Patient Name (Please print)

DOB:

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Signature of Patient or Responsible Party

Date

DATE/TIME OF SCHEDULED CONSULT REQUESTED BY: \_\_\_\_\_

VISIT: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

**PAST MEDICAL HISTORY – PLEASE ANSWER ALL AND REMEMBER TO BRING WITH YOU TO YOUR VISIT**

REASON FOR COMING TO SEE DOCTOR: \_\_\_\_\_

| REVIEW OF SYSTEMS   |   | REVIEW OF SYSTEMS   |  |
|---|---|---|--|
| <p><b>CONSTITUTIONAL</b></p> <p>Fever <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Fatigue <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Weight gain <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><b>HEENT</b></p> <p>Change in Vision <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Cataracts <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Change in Hearing <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Headaches <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Nose Bleeds <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><b>RESPIRATORY</b></p> <p>Shortness of Breath <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Cough <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Lung Disease <input type="checkbox"/> yes <input type="checkbox"/> no</p>  | <p><b>CVS</b></p> <p>Chest Pain <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Breathless on Exert <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>High BP <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Atrial Fib <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Heart Attack <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Irregular Beats <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Pacemaker <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Heart Surgery <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Heart Angioplasty <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Heart Stent <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Murmur <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Stress Test <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>High Cholesterol <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Cholesterol Meds <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Coumadin <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Plavix <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Aspirin <input type="checkbox"/> yes <input type="checkbox"/> no</p> | <p><b>NEURO</b></p> <p>Memory Loss:</p> <p>    Short Term <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>    Long Term <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Pin Stroke <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Stroke <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Dizziness <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Seizure <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Trouble Walking <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Walker <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Cane <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><b>MUSC/SKELETAL</b></p> <p>Joint Pain <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Back Pain <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Back Surgery <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Osteoporosis <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Arthritis:</p> <p>    Spine <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>    Hip <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>    Knee <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>    Foot &amp; Ankle <input type="checkbox"/> yes <input type="checkbox"/> no</p> | <p><b>PVS</b></p> <p>Pain Walking <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Sore/Ulcer Leg <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Amputation <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Prior Blood Clot <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Prior Phlebitis <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Extremity Swelling <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Varicose Veins <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Support Hose <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><b>HEMAT/LYMPH/IMMUNO</b></p> <p>Anemia <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Free Bleeding <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Bruising <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Cancer <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>HIV/Hepatitis <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Prior Transfusion <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Jehovahs' Witness <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Sickle Cell:</p> <p>    Disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>    Trait <input type="checkbox"/> yes <input type="checkbox"/> no</p> |
| <p><b>PRIMARY CARE DOCTOR:</b> _____</p>  |   | <p><b>HEART DOCTOR:</b> _____</p>   |  |
| <p><b>SKIN</b></p> <p>Rash <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Cancer <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Sore Not Healing <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Hair Loss <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><b>PSYCHOSOCIAL</b></p> <p>Anxiety <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Depression <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Stress in Life <input type="checkbox"/> yes <input type="checkbox"/> no</p>  | <p><b>GI</b></p> <p>Vomiting <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Nausea <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Heart Burn <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Constipation <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Ulcer Disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><b>OTHER</b></p> <p>Shellfish Allergy <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>X-Ray Dye Allergy <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Trouble With Anesthesia <input type="checkbox"/> yes <input type="checkbox"/> no</p>  | <p><b>ENDOCRINE</b></p> <p>Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Insulin <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Thyroid Disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Prednisone <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><b>GU</b></p> <p>Urinary Frequency <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Kidney Problems <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Dialysis <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Impotence <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Incontinence <input type="checkbox"/> yes <input type="checkbox"/> no</p>  | <p><b>MEDICATIONS</b></p> <p>Please attach a list of all of your medications you are currently taking or bring them with you.</p> <p><b>OTHER PHYSICIANS</b></p> <p>Please attach a list of all of the other doctors you are seeing.</p> <p><b>KIDNEY DOCTOR:</b> _____</p> <p><b>DIALYSIS DAYS:</b> _____</p>   |
| <p><b>FAMILY HISTORY:</b></p> <p>Heart Disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Heart Attack <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>High Blood Pressure <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Stroke <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Varicose Veins <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Blood Clot <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Amputation <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Bleeding Problems <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Anesthesia Problems <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Obesity <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Cancer <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Aneurysm <input type="checkbox"/> yes <input type="checkbox"/> no</p> |   | <p>Weight at Age 20: _____ Weight at Age 40: _____</p> <p><b>Exercise Program:</b> <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><b>Are you currently on a special diet?</b> <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><b>Smoker:</b> <input type="checkbox"/> yes #Packs per day: _____ #Years: _____<br/><input type="checkbox"/> no <input type="checkbox"/> quit/date stopped: _____</p> <p><b>Alcohol Use:</b> <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><b>OCCUPATION:</b> _____</p> <p><b>WHO LIVES WITH YOU:</b> _____</p>  |  |
|   |   | <p><b>PAST SURGICAL HISTORY</b></p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p><b>MEDICATION ALLERGIES:</b> _____</p>   |  |



**SAVANNAH VASCULAR AND CARDIAC INSTITUTE  
4750 WATERS AVENUE  
SUITE 500  
SAVANNAH, GA 31404**

## **Acknowledgement of Receipt of Privacy Notice**

I have received a copy of the Savannah Vascular and Cardiac Institute's Notice of Privacy Practices, which details how my personal health information may be used and disclosed as permitted under federal and state laws. I have read and understand the contents of the notice.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by the patient, please indicate the relationship to the patient of the person signing.

Relationship: \_\_\_\_\_ Witness: \_\_\_\_\_

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### Internal Use Only

If a patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on (date and time): \_\_\_\_\_

By (name and title): \_\_\_\_\_

## PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is, also, provided the right to request confidential communications of PHI to be made by alternative means, such as, sending correspondence to the individual's office instead of their home or allowing messages to be left on their home answering machine.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

Home Telephone: \_\_\_\_\_

Written Communication

O.K. to leave detailed message

O.K. to mail to my home address

Leave message with call back number only

O.K. to mail to my work/office

O.K. to fax to number listed below  
# \_\_\_\_\_

Work Telephone: \_\_\_\_\_

O.K. to leave detailed message on voice mail  
or with \_\_\_\_\_

Leave message with call back number only

**You may leave messages with, discuss my treatment, appointments, insurance coverage, and/or give information as necessary with the following family members, friends or personal representatives. I understand that Savannah Vascular and Cardiac Institute will refuse to discuss my information with anyone not listed below, except in an emergency. I understand that this disclosure does not apply to Medical Providers. I may edit this list at anytime by providing any changes in writing to the practice. I understand that it is my responsibility to inform the office of any/all contact changes.**

PLEASE PRINT:

1. \_\_\_\_\_

3. \_\_\_\_\_

2. \_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date