LAM VASCULAR & ASSOCIATES

Russell C. Lam, M.D., P.A.
*Board Certified in Vascular and Endovascular Surgery*

**Main/Dallas Office**
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**Rockwall Office**
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Rockwall, Texas 75032

Phone 214.345.4160 | Fax 214.345.4165

## PERSONAL INFORMATION

PATIENT NAME _____ SS# ____-____-____

SEX _____ MARITAL STATUS _____ DATE OF BIRTH ____/____/____ AGE _____

STREET ADDRESS _____ APT_____

CITY _____ STATE _____ ZIP_____ HOME PHONE ____-____-____

CELL PHONE ____-____-____ EMAIL _____

EMPLOYER _____

OCCUPATION _____ WORK PHONE ____-____-____

EMERGENCY CONTACT _____

PHONE _____ RELATIONSHIP TO PATIENT _____

REFERRING DOCTOR _____ PHONE _____

PRIMARY DOCTOR _____ PHONE _____

PHARMACY_____ PHONE_____

## MEDICAL INSURANCE INFORMATION

WERE YOU INJURED WHILE AT WORK? YES / NO DATE ____/____/____

DO YOU HAVE MEDICARE? YES / NO MEDICARE # _____

DO YOU HAVE MEDICAID? YES / NO MEDICAID # _____

DO YOU HAVE MEDICAL INSURANCE? YES / NO

NAME OF POLICY HOLDER _____ ID# _____

I request that payment of authorized Medicare/Other Insurance company benefits are made either to me or on my behalf to Russell C. Lam, M.D., P.A., for any service furnished by that party who accepts assignment. Medicare regulations pertaining to Medicare assignment of benefits apply.

**INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS**
All fees for professional services rendered by Russell C. Lam, M.D., P.A. are charged to the patient. Dr. Lam is a participating provider with Medicare. We agree to accept Medicare assignment and the patient is only held liable for the 20% not covered by Medicare. As a courtesy, necessary forms will be completed to help expedite health insurance payment. However, the patient will be responsible for all fees, regardless of insurance coverage. Any insurance claim not paid by the patients insurance companies in 60 days are billed directly to the patient. The patient may then seek reimbursement from their insurance company.

# CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Use and Disclosure of your Protected Health Information**
Your protected health information will be used by the Practice of Russell C. Lam, M.D., P.A. It will be disclosed to others solely for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

**Notice of Privacy Practices**
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this contract.

**Requesting a Restriction on the Use or Disclosure of Your Information**
You may request a restriction on the use or disclosure of your protected information.

The Practice of Russell C. Lam, M.D., P.A. may or may not agree to restrict the use or disclosure of your protected health information. If the Practice of Russell C. Lam, M.D.,P.A. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the consent.

**Revocation of Consent**
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of which your revocation of consent is received will not be affected.

**Reservation of Right to Change Privacy Practices**
The Practice of Russell C. Lam, M.D.,P.A. reserves the right to modify the privacy practices outlined in this notice.

**Authorization to Receive and Release Medical Records**

I _____ hereby authorize for Russell C. Lam, M.D.,P.A. Practice to receive and release any medical records for my proper health care treatment.

I have reviewed this consent form and give my permission to the Practice of Russell C. Lam, M.D.,P.A. to use and disclose my health information in accordance with it.

Print Name of Patient _____

Signature of Patient _____ Date _____

Witness _____ Date _____

Note: If any party other than the patient gives such consent, their capacity must be specified (i.e. Parent, Legal guardian's, etc)

Persons aged eighteen (18) years or older must authorize their own individual release of information.

## MEDICAL HISTORY

NAME _____

*Please list all medication(s) you are currently taking (include non-prescription medications, vitamins, herbs and/or appetite suppressants.) If additional space is needed, we will provide an additional page.*

**Medications:**

_____ **Dosage** _____ **Times per Day** _____

_____ **Dosage** _____ **Times per Day** _____

_____ **Dosage** _____ **Times per Day** _____

_____ **Dosage** _____ **Times per Day** _____

_____ **Dosage** _____ **Times per Day** _____

_____ **Dosage** _____ **Times per Day** _____

*Please list all allergies (including medications, shellfish, iodine, tape, latex, etc.)*

**Allergies:**

_____ **Reaction** _____

_____ **Reaction** _____

_____ **Reaction** _____

_____ **Reaction** _____

**Do you have any physical limitations?** YES / NO

**Explain** _____

**Have you ever had a blood transfusion?** YES / NO **Date** ___/___/___ **Reaction?** YES / NO

*Please list any surgeries and/or major procedures; indicate date below.*

**Surgeries/Procedures:**

_____ **Date** ___/___/___

_____ **Date** ___/___/___

_____ **Date** ___/___/___

_____ **Date** ___/___/___

**Have you ever been hospitalized for any reason besides surgery?** YES / NO

**Reason** _____

## REVIEW OF SYSTEMS

**NAME** _____

*Please circle any of the following medical problems you now have or have had in the past:*

**GENERAL**

Tuberculosis
High Blood Pressure
Polio
Stroke
Cataracts
Glaucoma
Gallstones
Diabetes
HIV/AIDS
Hiatal Hernia
Bleeding Problem
Rheumatic Fever
Leg cramps
Kidney Failure
Kidney Stones
Thyroid Problems
Head Injury
Blindness
Arthritis
Depression
Alcohol/Drug Abuse

Cancer - Type_____

Angina/Shortness of Breath - At Rest / With Exertion

**PULMONARY**

Emphysema
Pneumonia
Asthma
Blood Clot in Lung
Sleep Apnea
Wheezing

**CARDIAC**

Heart Attack
Coronary Artery Disease
Heart Valve Disease
Blood Clot in Vein
Blood Clot in Artery

**GASTROINTESTINAL**

Hepatitis
Peptic Ulcer

**Do you wear glasses?** YES / NO **Reason** Reading / Near-Sightedness / Far-Sightedness / Other

**Do any of your blood relatives (mother, father, sister, brother, child, grandparent) have any of the following?** *Please circle all that apply.*

| | | | |
|---|---|---|---|
| High Blood Pressure | Glaucoma | Kidney Failure | Heart Valve Disease |
| Heart Disease/Attack | Stroke | Tuberculosis | Diabetes |
| Epilepsy | Gout | Asthma | Thyroid Disease |
| Blood Disorders | Arthritis | Mental Disorders | |

Cancer - Type_____

**Usual Diet** _____

**Pregnant?** YES / NO **Last Menstrual Cycle?** ____/____/____

**Do you drink alcohol?** YES / NO **Circle:** Beer / Wine / Hard Liquor **# of 8oz glasses per day** _____
**Do you now or have you ever smoked?** YES / NO **# of packs per day** _____ **# of years** _____
**Do you use illicit drugs or abuse prescription medicines?** YES / NO
**Type** _____ **How often?** _____

**Do you exercise?** YES / NO **# times per week** _____ **# of minutes each time** _____
**Number of Children** _____ **Health Status:** Well / Chronic Illness / Deceased (#_____)

**Mother:** Living / Deceased **Age** _____ **or Cause of death (if known)** _____
**Father:** Living / Deceased **Age** _____ **or Cause of death (if known)** _____
**Number of Brothers and sisters** _____ **Health Status:** Well / Chronic Illness / Deceased (#_____)

## REVIEW OF SYSTEMS, continued

**The following questions relate to health problems you have or have had in the past. Please circle the appropriate conditions.**

**1. General:** Weight Loss / Weight Gain / Fatigue

**2. Neurological**: Seizures / Vertigo / Previous Stroke / Aneurysm / Hearing Impairment / Abnormal Speech Abnormal Gait / Double Vision / Other (_____)

**3. Ophthalmologic:** Glaucoma / Cataracts / Visual Impairment / Other (_____)

**4. Ear / Nose / Throat:** Snoring / Hearing Aids / Sinus / Hoarseness / Nose Bleeds

**5. Cardiac:** Ankle Swelling / Chest Pain / Dizziness / Shortness of Breath / Leg Pain / Palpitations Other (_____)

**6. Respiratory:** Coughing / Shortness of Breath / Wheezing / Other (_____)

**7. Gastrointestinal:** Bloody or Black Stools / Change in Bowel Habits / Hiatal Hernia / Reflux Esophagitis Esophageal Disease / Ulcers / Gastritis / Duodenitis / Hepatitis / Yellow Jaundice / Other Liver Disease Gallstones / Gallbladder Disease / Pancreatic Disease / Chronic Constipation / Diarrhea / Diverticulosis Diverticulitis / GI Bleed / Crohn's Disease / Ulcerative Colitis / Irritable Bowel / Other (_____)

**8. Endocrine/Hormonal:** Thyroid Disease / Adrenal Disease / Goiter / Other (_____)

**9. Musculoskeletal:** Joint Pain / Arthritis / Muscle / Weakness / Fibromyalgia / Fracture / Gout / Cramping

**10. Renal/Urological:** Prostrate Disease / Frequent Bladder Infections / Impotence / Hematuria / Incontinence / Nocturia

11. Skin: Psoriasis / Eczema / Petechiae / Pigmentation / Hair Loss / Foot Ulcers / Lesions / Lumps / Rashes / Nail Changes

**12. Immunological:** Gout / Rheumatoid Arthritis / Lupus / Other (_____)

**13. Infections:** AIDS / Hepatitis / TB / Syphilis / Endocarditis / Other (_____)

**14. Hematologic:** Anemia / Bleeding Problem / Clotting Problem / Leukemia / Other (_____)

**15. Psychological:** Depression / Anxiety / Panic Attacks / Anorexia / Bulimia / Other (_____)

**16. Physical Disability:** Problems With Walking / Other (_____)

**17. Vascular:** Varicose Veins / Aortic Aneurysm

**18. Malignancy:** Cancer / Tumor / Lymphoma

**19. Miscellaneous:** Osteoporosis / Congenital Syndrome / Marfan's / Turner's

I have reviewed the above information with the patient. _____ (M.D./MA)

Patient health history has been reviewed by _____ on _____/_____/_____.