LAM VASCULAR & ASSOCIATES

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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, MD PA may or may not agree to restrict the use or disclosure of your protected health information. If the Practice of Russell C. Lam, MD PA 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, MD PA 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, MD PA 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, MD PA 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

High Blood Pressure
High Cholesterol
Seizures
Severe Headaches
Visual Changes
Diabetes Type 1 or 2
HIV/AIDS
Leg Cramps
Chronic Back Pain
Kidney Failure
ESRD
Arthritis
Osteoarthritis
Alcohol/Drug Abuse
Liver Cirrhosis
Hepatitis A, B, C
Bleeding Problems
Factor 5 Leiden

PULMONARY

Emphysema
Blood Clot in Lung / PE
Sleep Apnea
Wheezing
COPD

CARDIAC

Heart Attack
Myocardial Infarction
CAD -Coronary Artery Disease
Heart Valve Disease
CHF
A-Fib

Vascular

PAD - Peripheral Artery Disease
Varicose Veins / Phlebitis
Lymphedema
Leg Swelling
DVT - Deep Vein Thrombosis
Blood Clot in Artery
Venous Insufficiency
Carotid Artery Disease
AAA Abdominal Aortic Aneurysm
May-Thurner's Syndrome

Cancer - Type_____

Angina/Shortness of Breath - At Rest / With Exertion

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?** ____/____/____

Date of last mammogram? _____ Results: ___ Normal ___ Abnormal

Date of last colonoscopy? _____ Results: ___ Normal ___ Abnormal

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 _____/_____/_____.