New Patient Paperwork

Date:______________________________

Please check the provider with whom you have a scheduled appointment.

☐ Lee Ferguson DO, FACS ☐ Ralph Pfeiffer Jr., MD FACS ☐ William Saliski CRNP
☐ Michael Hogan MD, FACS ☐ Nicholas Clapper DO

Name: Last ______________________________First____________________M____

Date of Birth:___/___/______Age______ Sex: M F SS# ______________________________

Marital Status: S / M / W / D Spouses Name: ______________________________

Mailing Address:____________________________City:____________________ST_____Zip:________

Home Phone:_______________Cell Phone:______________ Email: ____________________________

Referring Doctor: ____________________________________ City:__________________ ST: ________

Primary Care Doctor:____________________________________ City:________________ ST:______

Primary Insurance:___________________________ Group#:_______________Policy#:_____________

Policy Holder's Name: ______________________________ DOB:_________________________________

Secondary Insurance:_________________________Group#:_______________Policy#:_____________

Policy Holder's Name: ______________________________ DOB:_________________________________

How did you hear about Vascular Associates of South Alabama?
Please check all that apply:

☐ Doctor Name: ____

☐ Friend Name: ____

☐ Website ☐ Televison ☐ Radio ☐ Print/Newspaper ☐ Facebook

☐ Other ____

Last Name/ First Name_______________________________

(Please list all allergies)

ALLERGIES ____

Past Medical History (Check all that apply)

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Blood Clots
- ☐ Chronic Kidney Disease
- ☐ Aneurysm
- ☐ COPD/Lung Disease
- ☐ Stroke or TIA's
- ☐ Diabetes
- ☐ Dialysis
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ AFIB
- ☐ Vascular Disease/ Leg Pain
- ☐ HIV
- ☐ Heart Disease
- ☐ Cancer
- ☐ Heart Valve

MEDICATIONS

NAME STRENGTH (Mg) DOSAGE (How many times a day)?

____

____

____

____

____

PHARMACY INFORMATION

____

PHARMACY NAME ADDRESS PHONE NUMBER

Check all that apply	Mother	Father	Paternal Grand	Maternal Grand	Siblings	Children
Hypertension						
Diabetes						
Heart Disease						
DVT/Blood Clots						
Asthma						
COPD						
Stroke						
Aortic Aneurysm						
Varicose Veins						

Last Name/ First Name________________________________

SOCIAL HISTORY

	Y/N	How much?	How often?	Quit/ What year?
Smoking				
Tobacco				
Vaping/E Cigarettes				
Alcohol				

Do you have an Advanced Care Plan or Living Will?**

***If yes, we are required to keep a copy on file in your health record.*

☐ YES ☐ NO

Do you have a DNR (Do Not Resuscitate) Form ?**

***If yes, we are required to keep a copy on file in your health record.*

☐ YES ☐ NO

EMERGENCY CONTACT INFORMATION:

Note: By Providing an emergency contact you are authorizing Vascular Associates of South Alabama to discuss your person medical information with this person.

First, Last Name (please print) ________________________________

Phone Number with Area Code ________________________________

Relationship to Patient ________________________________

Last Name/ First Name______________________________

FINANCIAL POLICY

Vascular Assoicates of South Alabama (VASA) thanks you for choosing us as your medical provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. We sill complete and file insurance claims on your behalf, as a courtesy, however you, (as the responsible party) are responsible for all charges regardless of the status of any insurance claim.

We are required by your insurance company to collect co-pays and deductibles.

- **Copayments are due at the time of check in at each clinic visit.**
- **Patient deductibles must be paid in full prior to any procedure.**

Cancellation and Missed Appointment Policy:

Vascular Assoicates of South Alabama sets time aside to provide you with the highest quality of care in the clinic and during procedures. We understand that sometimes issues arise resulting in the need to cancel or reschedule, however we request you give our office at least 24-hours' notice prior to canceling an appointment or procedure. Failure to do so will result in a "no show" fee that will be billed directly to you and not your insurance company.

- **Effective May 1, 2023, any patient missing a clinic appointment** without the required 24hr. cancelation notice will be **charged a $50 "no show" fee.**
- **Missing a scheduled procedure will result in a $100 "no show" fee.**

Agreement to Pay: I, the undersigned, accept the fee charged as legal and lawful debt and agree to pay said fee including any/all collection agency fees (33.33%), attorney fees, and /or court costs as necessary, waving now and forever the right to claim exemption under the constitution and laws of the state of Alabama, or any other state:

I understand and accept the financial policy of Vascular Associates of South Alabama.

Patient Name (Print) ______________________________

Patient Signature ______________________________ **Date:** ______________________________

Last Name/ First Name________________________________

REVIEW OF SYSTEMS (Check all that apply)

CONSTITUTIONAL	☐ Fever/Chills ☐ Weight Loss ☐ Fatigue ☐ Recent Illness ☐ Weight gain ☐ Change in Appetite ☐ Wheelchair bound
HEENT	☐ Eye Pain ☐ Redness ☐ Sore Throat ☐ Sinus Problems ☐ Color Blind ☐ Vision Changes ☐ Headaches ☐ Nose Bleeds
RESPIRATORY	☐ Pain w/ Breathing ☐ O2 Dependent ☐ Shortness of Breath ☐ CPAP Machine ☐ BIPAP Machine ☐ Cough ☐ Wheezing ☐ Blood in Septum
CARDIOVASCULAR	☐ Chest Pain ☐ Palpitations ☐ Edema/Swelling ☐ Claudication
NEUROLOGICAL	☐ Dizziness ☐ Previous CVA/TIA ☐ Loss of Consciousness ☐ Weakness
GASTROINTESTINAL	☐ Abdominal Pain ☐ Diarrhea ☐ Vomiting ☐ Blood in Stool ☐ Nausea ☐ Heartburn ☐ Constipation
MUSCULOSKELETAL	☐ Back Pain ☐ Joint Pain ☐ Muscle Weakness ☐ Neck Pain ☐ Muscle Pain ☐ Cold Extremities
SKIN	☐ Rash ☐ Dryness ☐ Itching ☐ Wounds ☐ Color Change
HEMATOLOGY	☐ Bleeding Gums ☐ Prolonged Excessive Bleeding ☐ Easy Bruising
PERIPHERAL VASCULAR DISEASE	☐ Wounds ☐ Leg Cramps ☐ Leg Swelling ☐ Varicose Veins ☐ Numbness ☐ Amputation(s) ☐ Leg heaviness ☐ Discoloration ☐ Wounds ☐ Cold Extremities ☐ Pain in Extremities ☐ Tingling Feeling in Extremities
DIALYSIS	☐ Yes ☐ No

Past Surgery History (please list all)

________________________________ ________________________________

________________________________ ________________________________

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________________________________ ________________________________