VEIN & VASCULAR
OF DOTHAN

New Patient Information

Name: _____

DOB: _____ SSN: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Alternate Phone Number: _____

Race: _____ Language Spoken: _____

Marital Status: Married Single Divorced Widowed Partner

Email: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

Pharmacy Name: _____

Primary Care Physician: _____

.....

Primary Insurance Company: _____

Contract Number: _____

Secondary Insurance Company: _____

Contract Number: _____

By signing below, either personally or through the person legally empowered to give consent, I authorize this office, its employees' agents and other affiliates to provide general care for this and all subsequent requests for care. I hereby authorize this office of Vein and Vascular of Dothan dba Jason D Beaver MD LLC to release any medical information required during examination and treatment and permit payment directly to them and benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. I understand it is my responsibility to contact the practice with any additions from my original authorization for disclosure of Protected Health Information.

VEIN & VASCULAR
OF DOTHAN

HIPPA ACCESS FORM FOR PROTECTED HEALTH INFORMATION

I understand that it is the policy of Vein and Vascular of Dothan dba Jason Beaver MD LLC to restrict access to my protected health information. I understand that my medical records will be accessed by the caregiver(s) providing health services, and my insurance company for the payment of my claim(s). I understand that the following person/people listed will have access to my private health care information.

Patient Name: _____

Patient DOB: _____

NAME:	RELATIONSHIP:	PHONE NUMBER:

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Please Put Only the Date and Your Signature

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: _____

To: _____

PHYSICIANS NAME

_____

ADDRESS

_____

CITY STATE ZIP

_____

PHONE FAX

I hereby request that my medical records be released to:

Dr. Jason Beaver

2800 Ross Clark Circle Suite 2

Dothan, Alabama 36301

T: (334) 305-1848 Fax: (334) 305-1849

Patient Signature: _____ **Date:** _____

VEIN & VASCULAR

I hereby agree and consent as follows: if my account becomes delinquent it will be placed with Prim & Mendheim, LLC, for collection and subject to the following terms regarding any outstanding balance that I owe: (1) I will incur interest at the rate of one and one-half (1½) percent per month (18% per annum); (2) in addition to the outstanding balance, I will be responsible for reasonable collection costs, attorney's fees, and costs of court incurred in the collection of same, whether such outstanding balance is satisfied prior to or after initiation of a lawsuit, or after a judgment has been entered in a lawsuit; and (3) any lawsuit or legal proceeding resulting from the outstanding balance and debt shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and objections to said jurisdiction. By signing below, I affirmatively acknowledge that I have read the same before signing. Furthermore, I can be contacted regarding my balance on my cell phone and I hereby waive any and all state and federal personal property exemptions, wage exemptions, and homestead exemptions of my state of residence and state of operation in the event of judgment, levy, or garnishment. Finally, if I reside in Florida I hereby waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance.

I have read and understand the terms of this policy statement.

_____ _____

Print Patients Name Date

_____ _____

Patient's Signature (Parent or Guardian if Minor) Date

_____ _____

Signature of Insured if other than Patient Date

VEIN & VASCULAR
OF DOTHAN

Patient History

Name: _____ DOB: _____

Primary Physician: _____ Referring Physician: _____

Personal Medical History –

Please check any medical conditions that you currently have or have had in the past.

__ Acid Reflux	__ Diabetes	__ Depression
__ Alcoholism	__ Diverticulitis	__ Kidney Disease
__ Anemia	__ Emphysema	__ Liver Disease
__ Anorexia	__ Epilepsy/ Seizures	__ Lung Disease
__ Arthritis	__ Gallstones	__ Mental Illness
__ Asthma	__ Heart Disease	__ Osteoporosis
__ Atrial Fibrillation	__ Hepatitis	__ Stroke
__ Bleeding Disorder	__ High Blood Pressure	__ Thyroid Disease
__ Blood Clots	__ High Cholesterol	__ Tuberculosis
__ Cancer Typer:	__ HIV/ AIDS	__ Ulcer
__ Colitis	__ Irritable Bowel	__Wound
__ Other	__ Other	__ Other

Previous Surgeries -

List all past surgeries and approximate date

Medication Allergies-

Medications -

Please list medication names and dosages or you can provide a list.

Family History-

Check if Mother, Father, Sibling or Children have/ had the following and list relationship.

___ Cancer
___ Heart Disease
___ Kidney Disease
___ Mental Illness
___ Diabetes

Social History -

Check which of the following applies to you.

Tobacco: __ Current __ Former ___Never

Alcohol: ___ Yes ___ No

Other Substances: ___ Yes ___No

Advance Directive: ____ Living Will ____ POA ____ Organ Donor

Have you had a fall in the past year? ____ Yes ____ No

Signature: _____ Date: _____