

New Patient Information

Name:			
DOB:			
Street Address:			
City:	State:	Zip:	
Phone Number:	Alternate	Phone Number:	
Race:	Language Spoke	guage 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.



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.

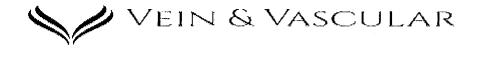
Patient Name: _____

Patient [OOB:	
NAME:	RELATIONSHIP:	PHONE NUMBER:
Dationt Signature	Dat	e:
Patient Signature:		
Witness Signature:	Date	2:

Please Put Only the Date and Your Signature

REQUEST FOR RELEASE OF MEDICAL RECORDS

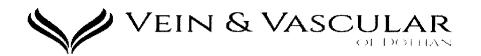
Date:	<u> </u>		
To:PHYSICIANS NAME			
ADDRESS			
CITY	STATE	ZIP	
PHONE		FAX	_
I hereby request t	hat my medical records	be released to:	
Dr. Jason Beaver			
2800 Ross Clark Circle Suite 2			
Dothan, Alabama	36301		
T: (334) 305-184	48 Fax: (334) 305-184	9	
Patient Signature:	<u> </u>	Date:	



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.

Print Patients Name	Date
Patient's Signature (Parent or Guardian if Minor)	Date
Signature of Insured if other than Patient	 Date

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



Patient History

Name:		DOB:
Primary Physician: _	Refe	erring Physician:
	Personal Medical	History –
Please check any med	ical conditions that you c	urrently have or have hac
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
List	Previous Surge all past surgeries and app	
	Medication Alle	ergies-

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:CurrentFormerNever
Alcohol: Yes No
Other Substances: YesNo
Advance Directive: Living Will POA Organ Donor
Have you had a fall in the past year? Yes No
Signature: