LAKE WASHINGTON VASCULAR

PATIENT REGISTRATION

Name: ____
Last First MI

Address: ______________________ City: ____________ State: ______ Zip: ______

Messages may be left on:
❒ Answering Machine/Voice Mail ❒ Work Phone

Home Phone:	Work Phone:	Cell Phone:
(____) __________	(____) __________	(____) __________

Email Address:

Sex: ❒ F ❒ M Date of Birth: ____ / _____ / _____

Social Security # :___________-_______- __________

Patient's Employer: ______________________________

Occupation: ______________________________

Marital Status: ❒ Single ❒ Married ❒ Widow/Widowed

Spouse's Name: ______________________________

REFERRING PHYSICIAN(S)

Referred By: M.D. ❒ N.P. ❒ Friend ❒ ______________________________
(Last) (First) (Phone #)

Primary Care Physician: ______________________________
(Last) (First) (Phone #)

Send additional reports to the following physicians: ______________________________
Name Phone #

______________________________ ______________________________
Name Phone # Name Phone #

INSURANCE

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD, AND PAY YOUR APPLICABLE CO-PAYMENT.

Primary Insurance: ______________________________

Secondary Insurance: ______________________________

❒ **No Insurance**

Emergency Information: Person to contact in case of emergency, NOT LIVING at the above address.

Name: ______________________ Relationship to Patient: ______________

Address: ______________________ Phone: (_________) ______________

City: ____________ State: ___ Zip: ________

I authorize the physicians and staff of Lake Washington Vascular to release information regarding my condition and/or treatment to: ______________________________

Please read the following statement carefully before signing.

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to receive all benefits to which my dependents or I are entitled to under my health insurance plan. I also authorize the healthcare provider or insurance company to release any information required for this claim. In addition, I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have also been informed of the $35.00 fee (per RCW 62A.3-515&520) on checks returned from my bank NSF. The undersigned agrees that whether he/she signs as an agent, that he/she is obligated to pay for the account. Past due balance will be charged 1% interest per month (per RCW 19.52) on the unpaid balance.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature: ______________________ Relationship to Patient: ______________

Date: ______________________

PERSONAL MEDICAL HISTORY

NAME: ______________________ **AGE:** ________ **DATE:** ________

REASON FOR VISIT: ______________________

Do you have or have you ever had any of the following medical problems:

YES	NO	**Cardiovascular**
_____	_____	High Blood Pressure
_____	_____	Coronary Artery Disease
		Stent - Angioplasty - Heart Bypass (circle)
_____	_____	Heart Attack
_____	_____	Congestive Heart Failure
_____	_____	Irregular Heart Rhythm
_____	_____	Pacemaker or Defibrillator
_____	_____	Aneurysm - Where? ______________
_____	_____	Peripheral Vascular Disease
_____	_____	Blood Clot - Where? ______________
_____	_____	Pulmonary Embolus
_____	_____	Varicose Veins
_____	_____	Spider Veins
_____	_____	Phlebitis
_____	_____	High Cholesterol
_____	_____	Other - List: ______________________
		Pulmonary
_____	_____	Asthma
_____	_____	Chronic Bronchitis
_____	_____	Emphysema
_____	_____	Pneumonia
_____	_____	Other - List: ______________________
		Neurological
_____	_____	Stroke
_____	_____	TIA (mini-stroke)
_____	_____	Migraine Headaches
_____	_____	Other - List: ______________________
		Gastrointestinal
_____	_____	Acid Reflux (GERD)
_____	_____	Ulcers
_____	_____	Gallbladder Disease
_____	_____	Liver Disease / Hepatitis
_____	_____	Hernia
_____	_____	Irritable Bowel Syndrome (IBS)
_____	_____	Hemorrhoids
_____	_____	Other - List: ______________________
		Skin
_____	_____	Skin Ulcers - Where? ______________
_____	_____	Dermatitis
_____	_____	Other - List: ______________________

YES	NO	**Genitourinary**
_____	_____	Kidney Failure
_____	_____	Are you on dialysis? Type: hemo / peritoneal
_____	_____	Kidney Stones
_____	_____	Incontinence
_____	_____	Enlarged Prostate
_____	_____	Impotence, Erectile Dysfunction
_____	_____	Other - List: ______________________
		Endocrine/Other
_____	_____	Cancer - Type: ____________________
		Treatment: ____________________
_____	_____	Diabetes - Type: Type 1 / Type 2
_____	_____	Fibromyalgia
_____	_____	Thyroid Disease
_____	_____	Lupus
_____	_____	HIV/AIDS
_____	_____	Other - List: ______________________
		Psychiatric
_____	_____	Depression
_____	_____	Anxiety
_____	_____	Other - List: ______________________
		Musculoskeletal
_____	_____	Back Problems
_____	_____	Neck Problems
_____	_____	Arthritis
_____	_____	Gout
_____	_____	Osteoporosis
_____	_____	Treatment for chronic pain?
_____	_____	Other - List: ______________________
		Head/Neck/ENT
_____	_____	Hard of Hearing
_____	_____	Cataracts
_____	_____	Glaucoma
_____	_____	Legally Blind
_____	_____	Other - List: ______________________

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES / NO

List name(s) and reaction(s):

SURGICAL HISTORY

DATE	DESCRIPTION	HOSPITAL AND SURGEON

MEDICATIONS (Prescription and Non-Prescription)

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

CURRENT HEIGHT: ___________ **WEIGHT:** ___________

FAMILY MEDICAL HISTORY (blood relatives only)

		CONDITION	RELATIONSHIP			CONDITION	RELATIONSHIP
Yes	No	**Heart Disease**		Yes	No	**High Blood Pressure**	
Yes	No	**Diabetes**		Yes	No	**Varicose Veins**	
Yes	No	**Cancer - Type:**		Yes	No	**Blood Clots**	
Yes	No	**Stroke**		Yes	No	**Aneurysm**	

SOCIAL HISTORY

Tobacco: (circle) Never / Now / Past

Type: (circle) Cigarettes / Chew / Pipe / Cigars

How long have you been smoking? ___________

How many packs per day? ___________

Date you quit? ___________

How long did you smoke? ___________

If still smoking, do you have plans to quit? ___________

Living Situation: (circle all that apply)

Your Home / Assisted Living / Alone / With Family, Friends

Alcohol: (circle) None / Rare / Daily / Weekly

How may drinks do you have per day____or week____

Has alcohol been a problem in the past? (circle) Yes / No

Do you use any other substances? (circle) Yes / No

If so, please list: _________________________________

Children: How many? _____ Ages: ______________

REVIEW OF SYSTEMS

Are you CURRENTLY experiencing any of the following symptoms?

Yes	No	
		Constitutional Symptoms
_____	_____	Unintentional weight gain/loss
_____	_____	Fever
_____	_____	Other - List: __________________
		Cardiovascular
_____	_____	Chest pain
_____	_____	Heart palpitations
_____	_____	Swelling in legs
_____	_____	Pain in legs ONLY when walking
_____	_____	Other - List: __________________
		Respiratory
_____	_____	Shortness of Breath
_____	_____	Cough
_____	_____	Wheezing
_____	_____	Other - List: __________________
		Gastrointestinal
_____	_____	Abdominal pain
_____	_____	Heartburn
_____	_____	Nausea/Vomiting
_____	_____	Constipation
_____	_____	Chronic diarrhea
_____	_____	Blood in stool
_____	_____	Recent change in bowel habits
_____	_____	Jaundice (yellowing skin/eyes)
_____	_____	Other - List: __________________

Yes	No	
		Genitourinary
_____	_____	Pain/burning with urination
_____	_____	Frequent urination
_____	_____	Incontinence
_____	_____	Blood in urine
_____	_____	Difficulty starting urine stream
_____	_____	Other - List: __________________
		Musculoskeletal
_____	_____	Back Pain
_____	_____	Neck Pain
_____	_____	Joint pain Where? _____________
_____	_____	Muscle pain Where? _____________
_____	_____	Other - List: __________________
		Skin
_____	_____	Rash
_____	_____	Itching
_____	_____	Change in skin color
_____	_____	Ulcers
_____	_____	Wounds
_____	_____	Other - List: __________________
		Neurological
_____	_____	Sudden change in consciousness
_____	_____	Transient change in speech
_____	_____	Transient weakness in arm or leg
_____	_____	Sudden or severe headache
_____	_____	Sudden vision change
_____	_____	Other - List: __________________

NAME: ____ **DATE:** __________________

AUTHORIZATIONS & CONSENTS

PATIENT NAME ____

DATE OF BIRTH _________________________

PLEASE CHECK ALL THAT APPLY:

- **May leave detailed message on voicemail at home # (_____) ___________________________**
- **May leave detailed message on voicemail at work # (_____) ___________________________**
- **May leave information with spouse (Name) ____**
- **May leave detailed message on cell phone # (_____) __________________________________**
- **May send detailed message by email to ____**

PHOTO CONSENT

**** I understand that my medical photos may be required by insurance carriers in order to authorize procedures or payments to Lake Washington Vascular. Your name must be attached to your claim.***

_____ ***Initials only***

*** I will _____ will not _____ allow my medical photos to be used by Lake Washington Vascular for the following purposes:**

_____ Patient Education

_____Marketing purposes

I understand my identity and personal information will remain confidential. I also understand that I may revoke permission at any time.

PERMISSION TO CONTACT FOR RESEARCH

Lake Washington Vascular participates in clinical research trials to help advance the understanding and treatment of vascular disorders. If you are a candidate for a research trial, may we contact you to discuss possible participation?

Yes ____________________ No ___________________

I acknowledge and understand this information will be kept in my Medical Record. It is my responsibility to notify Lake Washington Vascular should any of these authorizations and consents change.

____

Signature---Patient or legally authorized individual Date

FINANCIAL POLICY

We hope that you will understand that our credit and collection policies are necessary to insure the financial resources to maintain health care services for our patients and the community. The responsibility for payment of fees is the direct obligation of the patient. Patients are also responsible to provide accurate insurance information and current referrals, if required. Any financial benefits that you may receive from your insurance company or governmental agency is strictly an agreement between you and the agency involved unless Lake Washington Vascular has formally contracted with the insurance or government plan.

Contracted Plans:

Lake Washington Vascular is contracted with the following companies:

Regence, Premera, UnitedHealthCare, Aetna, Cigna, First Choice, Uniform Medical, Great West, Medicare, DSHS and L & I.

We will submit the required billing forms and will accept the contracted fee schedule as payment in full. Patients are responsible for deductibles and co-insurance amounts. Statements are mailed monthly for patient balances due.

Co-payments are due at the time of service and will be collected by our staff when checking in. We accept cash, checks, Visa, Mastercard and American Express.

Non-Contracted Plans:

If you are unsure about whether Lake Washington Vascular is contracted with your insurance carrier, please visit their web site or call their customer service phone number listed on the back of your insurance card. We will still submit the billing for all carriers but we will not be able to tell you what your patient balance will be. Out-of Network benefits often result in higher out-of-pocket amounts due from patients.

Collections process:

Our collection staff will work with you to set up payment plans but we do require your commitment to the plan. In the event that your account becomes past due, and you have not made prior payment arrangements, the account will be forwarded to our collection agency.

Please sign and date the following agreement: I have read and understand that I am financially responsible for all charges whether or not covered or denied (due to medical necessity) by my insurance carrier. I also authorize my insurance benefits to be paid directly to Lake Washington Vascular.

____ ________________

Signature **Date**