VALLEY SURGICALIST GROUP

David Terry, DO
Farid Zehtab, DO
Antonino Cammarata, DO
Nick Gabriel, DO
Michael Stumpf, DO
Ian Thomas, DO
Regan Alford, PA-C

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Sex: _____ SS#: _____ - ____ - _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

If you are a winter visitor, please list:

Local Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Marital Status: ☐Single ☐Divorced ☐Widowed ☐Married – Spouse's Name: _____

Referred by: ☐Physician Name: _____ ☐Other: _____ Phone: (____)_____

Primary Care Physician (if other than referring physician): _____ Phone: (____)_____

PRIMARY INSURANCE

Policy Holder: ☐Self ☐Spouse ☐Child ☐Other: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ SS#: _____-____-_____

Employer: _____

Policy #: _____ Group #: _____

Plan Name: _____

Plan Address: _____

City: _____ State: _____ Zip: _____

Plan Phone: _____

SECONDARY INSURANCE

Policy Holder: ☐Self ☐Spouse ☐Child ☐Other: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ SS#: _____-____-_____

Employer: _____

Policy #: _____ Group #: _____

Plan Name: _____

Plan Address: _____

City: _____ State: _____ Zip: _____

Plan Phone: _____

RESPONSIBLE PARTY INFORMATION

Please complete if responsible party is other than patient:

Name of Responsible Party: _____ DOB: _____ SS#: _____-____-_____

Relationship to Patient: ☐Spouse ☐Parent ☐Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____

PAYMENT BENEFITS/MEDICAL RELEASE AUTHORIZATION

- As the responsible party, I agree that all charges are my responsibility and my insurance carrier will be billed as a courtesy.
- I authorize payment of medical benefits to *Valley Vascular Consultants / Valley Surgicalist Group* for services rendered.
- I hereby authorize *Valley Vascular Consultants* to release all medical information required to process payment of insurance claims.

Patient/Responsible Party: _____ Date: _____

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PATIENT HISTORY

Name: _____ Age: ____ Date of Birth: _____ Today's Date: _____

List other doctors treating you: _____

Main complaint: _____ Date of onset: _____

DO YOU HAVE A HISTORY OF:

Tuberculosis	❑No ❑Yes	Lung Disease	❑No ❑Yes	Gout	❑No ❑Yes
Diabetes	❑No ❑Yes	Kidney Disease	❑No ❑Yes	Stomach/Ulcer Problem	❑No ❑Yes
Heart Disease	❑No ❑Yes	Hepatitis	❑No ❑Yes	Arterial Insufficiency	❑No ❑Yes
High Blood Pressure	❑No ❑Yes	Blood Transfusion	❑No ❑Yes	Venous Stasis	❑No ❑Yes
Colon Polyps	❑No ❑Yes	Chemical Dependence	❑No ❑Yes	Stroke	❑No ❑Yes
Asthma	❑No ❑Yes	Bleeding Tendency	❑No ❑Yes	Paralysis	❑No ❑Yes
Breast Cancer	❑No ❑Yes	Colitis	❑No ❑Yes	Seizures	❑No ❑Yes
Colon Cancer	❑No ❑Yes	Arthritis	❑No ❑Yes	Anesthesia Problems	❑No ❑Yes
Other Cancer – Type: _____		Location: _____			

LIST ALL PAST OPERATIONS AND SERIOUS ILLNESSES:

Type of Operation or Illness	Month and Year	City and State

Recent x-rays, labs or tests	Date	Facility/Doctor

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Medication	Dose	Frequency	For what condition?

Do you have allergies to any medications? ❑No ❑Yes – please list: _____

Do you have any non-medication allergies: ❑No ❑Yes – please list: _____

Do you smoke? ❑No – Date quit: _____ ❑Yes – How much? _____

Do you drink alcohol? ❑No – Date quit: _____ ❑Yes – How much? _____

Previous steroid use? ❑No – Date quit: _____ ❑Yes – How much? _____

FAMILY HISTORY	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
☐ Brother ☐ Sister				
☐ Brother ☐ Sister				

HAS ANY BLOOD RELATIVE EVER HAD:

Tuberculosis	❑No ❑Yes	Relative: _____	Lung Disease	❑No ❑Yes	Relative: _____
Diabetes	❑No ❑Yes	Relative: _____	Stroke	❑No ❑Yes	Relative: _____
Heart Disease	❑No ❑Yes	Relative: _____	Arthritis	❑No ❑Yes	Relative: _____
High Blood Pressure	❑No ❑Yes	Relative: _____	Atherosclerosis	❑No ❑Yes	Relative: _____
Bleeding Tendency	❑No ❑Yes	Relative: _____	Kidney Disease	❑No ❑Yes	Relative: _____
Colon Cancer	❑No ❑Yes	Relative: _____	Anesthetic Reaction	❑No ❑Yes	Relative: _____
Colitis	❑No ❑Yes	Relative: _____	Congenital Deformity	❑No ❑Yes	Relative: _____
Breast Cancer	❑No ❑Yes	Relative: _____			

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PATIENT AGREEMENT

The patient, or patient's authorized agent or representative, agrees to the following terms of service:

CONSENT TO TREATMENT: The Patient voluntarily agrees to be evaluated/treated by Provider. This consent is valid and continuing until the Patient is discharged from care.

FINANCIAL AGREEMENT: The Patient agrees, in return for services provided, to pay his/her account balance in full or to make arrangements for payment that are satisfactory to the Provider. To the extent not expressly prohibited by applicable law, the Patient agrees to pay all charges not paid in full by his/her insurance carrier or a third-party payer such as the anesthesiologist, surgical assistant, or hospital. The Patient also agrees to pay reasonable attorney fees and collection expenses if the account is sent to collections.

ASSIGNMENT OF INSURANCE BENEFITS: If Patient is entitled to any policy of insurance that insures the Patient, or any party liable to the Patient, Patient hereby assigns all such benefits to be applied to the Provider. Patient requests that payment of authorized benefits, when received, be made to the Provider. Patient authorizes release of any information needed to act on this request. It is understood, however, that the Patient remains responsible for payment of his/her bill in full regardless of Patient's assignment of insurance coverage. I understand that I am responsible for my health insurance deductibles, co-payments and co-insurance.

MEDICARE PATIENTS: The undersigned certifies that all information given in applying for payment under title XVIII of the Social Security Act is correct. Patient requests that payment of authorized benefits, when received, be made to the Provider. Patient authorizes release of any information needed to act on this request.

PRICE QUOTES: The Patient understands that any price quotations given are estimates of expected services and not a guarantee.

FMLA/DISABILITY FORMS: A $25.00 fee is required for each form completed by the physician.

PRIVACY NOTICE: I acknowledge VSG's Notice of Privacy Practices as displayed in the waiting room. A copy of the notice is available upon request.

I authorize release of medical information to my referring provider, and the following individuals listed below:
Name: _____ Relationship: _____ Phone: (_____) _____-_____

Name: _____ Relationship: _____ Phone: (_____) _____-_____
MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND UNDERSTAND THESE CONDITIONS OF SERVICE, AND THAT I AM THE PATIENT OR AM DULY AUTHORIZED BY THE PATIENT AS PATIENT'S AGENT TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS.

_____ _____
Patient's Printed Name — Date Signed

_____ _____
Signature of Patient, Patient's Agent or Representative — Relationship to Patient