



PATIENT'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ SOCIAL SECURITY #: _____

EMAIL ADDRESS: _____

WOULD YOU LIKE TO RECEIVE EMAILS REGARDING MONTHLY SPECIALS? ____ YES ____ NO

MARITAL STATUS: S M D W IF MARRIED SPOUSE'S NAME: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____

PRIMARY INSURANCE: _____

ID # _____ GROUP: _____

SUBSCRIBER NAME: _____ EMPLOYER NAME: _____

SECONDARY INSURANCE: _____

ID # _____ GROUP: _____

EMERGENCY CONTACT:

NAME: _____ PHONE: _____

RELATION TO PATIENT: _____

I certify that I have read and agree to Cardiothoracic & Vascular Surgeons, LTD/Dr. Pang's payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I authorize Dr. Pang to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances, within 90 days of notification of the amount due, will result in submission to an outside collection agency. A \$35.00 returned check fee will be charged for checks returned due to insufficient funds.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Cardiothoracic & Vascular Surgeons, LTD/Dr. Pang. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. I authorize Dr. Pang to request any medical records or information that may be necessary for my medical care.

PATIENT'S SIGNATURE: _____ DATE: _____

Venous History Questionnaire

Name _____ Age _____ Date of Birth _____

Ethnicity _____ City _____ Occupation _____

Problem/Progression/Complications: _____

How long have your legs bothered you? _____

Have you ever worn compression stockings? YES NO

Does one leg bother you more than the other? RIGHT LEFT EQUALLY

Have you or any of your family members traveled outside of the US recently? Yes No

Have you recently been sick with the flu or have had flu like symptoms? Yes No

If yes, what symptoms? Fever Headache Vomiting Diarrhea Sore Throat

Other: _____

Below are some questions about your legs. This information will help keep track of how you feel and how well you are able to do your usual activities.

1. During the past 4 weeks, how often have you had any of the following leg problems?

<i>(check one box on each line)</i>	Every Day	Several times a week	About once a week	Less than once a week	Never
Heavy/Full legs					
Aching/Throbbing legs					
Swelling					
Night cramps					
Heat or burning sensation					
Restless legs					
Itching					
Tingling sensation (e.g. pins and needles)					
Muscle fatigue					
Pain					
Bleeding					
Pelvic symptoms					
Easily bruise					

2. At what time of day are your leg symptoms the most intense? (circle one)

- | | |
|--------------------------|---------------------------|
| 1. On waking | 4. During the night |
| 2. At mid-day | 5. At any time of the day |
| 3. At the end of the day | 6. Never |

3. Compared to one year ago, how would you rate your **leg problem** in general now? (Circle one)

- | | |
|--------------------------------------|--|
| 1. Much better than one year ago | 4. Somewhat worse than one year ago |
| 2. Somewhat better than one year ago | 5. Much worse than one year ago |
| 3. About the same as one year ago | 6. I did not have any leg problems last year |

4. The following items are about activities that you might do in a typical day. Does your leg problem now limit you in these activities? If so, how much?

<i>(check one box on each line)</i>	Not applicable	YES, limited a lot	YES, limited a little	NO, not limited at all
Daily activities at work				
Daily activities at home (e.g. housework, ironing, doing odd jobs/repairs, gardening, etc.)				
Social or leisure activities in which you are <u>standing</u> for long periods (e.g. parties, weddings, shopping, etc.)				
Social or leisure activities in which you are <u>sitting</u> for long periods (e.g. going to the cinema, theatre, travelling, etc.)				

5. During the past 4 weeks have you had any of the following problems with your work or regular daily activities **as a result of your leg problem**?

<i>(check one box on each line)</i>	YES	NO
Cut down the amount of time you spent on work and other activities		
Accomplished less than you would like		
Were limited in the kind of work or other activities		
Had difficulty performing the work or other activities (for example, it took extra effort)		

6. During the past 4 weeks, to what extent has your leg problem interfered with your normal social activities with family, friends, neighbors, or groups? (circle one)

- | | |
|---------------|----------------|
| 1. Not at all | 4. Quite a bit |
| 2. Slightly | 5. Extremely |
| 3. Moderately | |

7. How much leg pain have you had in the past 4 weeks? (circle one)

- | | |
|--------------|----------------|
| 1. None | 4. Moderate |
| 2. Very mild | 5. Severe |
| 3. Mild | 6. Very severe |

8. These questions are about how you feel and how things have been with you during the past 4 weeks as a result of your leg problem. For each question, please give the answer that comes the closest to the way you have been feeling. How much time during the past 4 week-

<i>(check one box on each line)</i>	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you felt concerned about the appearance of your legs?						
Have you felt irritable?						
Have you felt like a burden to your family or friends?						
Have you been worried about bumping into things?						
Has the appearance of your leg(s) influenced your choice of clothing?						

Preferred Pharmacy: _____ Phone: _____ Address: _____

Patient Signature: _____ **Date:** _____

INTER OFFICE USE ONLY:

Ht: _____ Wt: _____ T: _____ P: _____ R: _____ BP: _____

Compression Stocking Measurement: Ankle: _____ Calf: _____ Thigh: _____

Reflux Seen: RIGHT LEFT BILATERAL NOT SEEN

Comments: _____

Provider: _____ Witness: _____

Name: _____ Date of Birth: _____

Medical History:

Do you have or have you ever been treated in the past for:

Migraines or other headaches?	Yes	No
Stroke/TIA?	Yes	No
Carotid Artery Disease (blockages in the neck arteries)?	Yes	No

COPD/Empehezema?	Yes	No
Asthma?	Yes	No
Other Respiratory/Lung Conditions? _____		

High Blood Pressure?	Yes	No
High Cholesterol?	Yes	No
Coronary Artery Disease?	Yes	No
Heart Attack? (If yes, when?) _____	Yes	No
Other Heart Conditions? _____		

Thyroid Problems?	Yes	No
Diabetes?	Yes	No
GERD?	Yes	No
Kidney Disease/Kidney Failure/Kidney Transplant?	Yes	No
Gout?	Yes	No
Arthritis?	Yes	No
PVD/PAD?(If yes, treatment) _____		
Cancer? (If yes, type and treatment) _____		

Other Medical/Health Conditions not listed above?

What surgeries have you ever undergone in your lifetime?

Name: _____ Date of Birth: _____

In the **past year** have you had any of the following? (If yes, please explain)

Unexplained 10 lb. weight gain or loss?	Yes _____
Vertigo?	Yes _____
Visual disturbances?	Yes _____
Hearing loss?	Yes _____
Sinusitis?	Yes _____
Shortness of breath?	Yes _____
Wheezing?	Yes _____
Unexplained cough?	Yes _____
Chest pain?	Yes _____
Palpitations?	Yes _____
Abdominal pain?	Yes _____
Unexplained nausea or vomiting?	Yes _____
Blood in sputum, urine, or stool?	Yes _____
Unexplained diarrhea or constipation?	Yes _____
Syncope?	Yes _____
Seizures?	Yes _____
Tremors?	Yes _____
Changes in mentation or memory?	Yes _____
Joint swelling, tenderness or stiffness?	Yes _____
Abnormal skin pigmentation, rashes, or itching?	Yes _____
Abnormal bleeding, easy bruising?	Yes _____
Blood disorder?	Yes _____

Family History:

Did any of your blood relatives (parents or siblings) ever have a heart attack? Yes No
If yes, at what age: _____

Social History:

Do you or have you ever smoked? Yes No
When was the last time you had a cigarette? _____
How old were you when you had your first cigarette? _____
Most number packs a day you ever smoked? _____

Do you drink alcohol? Yes No
If yes, how much? _____
What types? _____

Do you use recreational drugs? Yes No
If yes, what types? _____



NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about our patients may be used and disclosed. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996. (HIPAA). This notice is effective as of 4/14/03 and will remain in effect until we replace it.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or a law enforcement official.
8. For Workers Compensation and similar programs.
9. To remind you of needed appointments in the near future by way of a mailed postcard.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in the patient's care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, please ask the front desk receptionist.
4. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable laws.

If you have any questions regarding this notice please ***let us know!!!***

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices for Cardiothoracic & Vascular Surgeons, LTD.

Signature of Patient _____

Name of Patient _____ Date _____



Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- Home Telephone _____
- Ok to leave message with detailed information
- Leave message with call back number only

- Written Communication
- Ok to mail to my home address
- Ok to mail to my work/office address
- Ok to fax to this number

- Work Telephone _____
- Ok to leave message with detailed information
- Leave message with call back number only

- Other _____

Patient Signature

Date

Print Name

Birthdate

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to who Address or Fax number		By whom Disclosed		

YOUR INSURANCE NEEDS TO KNOW HOW YOUR LEG SYMPTOMS AFFECT YOUR ACTIVITIES OF DAILY LIVING (ADL'S)

IF YOU ARE RESPONSIBLE FOR THE FOLLOWING, DO YOUR LEG SYMPTOMS PREVENT YOU FROM COMPLETING THE TASKS OR DO YOU HAVE TO TAKE FREQUENT BREAKS TO ACCOMPLISH THE TASK(S)?

HOME:

TASK	I'M UNABLE TO DO THIS TASK DUE TO MY LEG SYMPTOMS	I FREQUENTLY HAVE TO STOP AND REST AND/OR ELEVATE MY LEGS	I SOMETIMES HAVE TO STOP AND REST AND/OR ELEVATE MY LEGS	I'M ABLE TO COMPLETE THIS TASK WITHOUT ANY LEG SYMPTOMS	NOT APPLICABLE
WASHING DISHES					
VACUUMING					
GROCERY SHOPPING					
GARDENING					
PREPARING MEALS					
MISC HOUSEWORK					
HOUSEHOLD MAINTENANCE/HANDY					
LAUNDRY					
TRANSPORTATION					
EXERCISING					

WORK:

IF YOUR JOB REQUIRES A LOT OF STANDING, DO YOU NEED TO TAKE FREQUENT BREAKS TO REST YOUR ACHING AND OR SWOLLEN LEGS?

IF YOUR JOB REQUIRES A LOT OF SITTING, DO YOU NEED TO TAKE FREQUENT BREAKS TO STRETCH YOUR ACHING OR SWOLLEN LEGS?

IS YOUR ABILITY TO EFFECTIVELY DO YOUR JOB AFFECTED BY YOUR LEG SYMPTOMS?