PATIENT DEMOGRAPHICS

PATIENT INFORMATION:

Patient Name: _____ **SSN:** _____

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

Home Number: _____ **Cell Number:** _____ **Work Number:** _____

Email Address: _____

Date of Birth: _____/_____/_____ **Sex:** ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ American Indian or Alaskan Native, ☐ Asian, ☐ Black or African American, ☐ Caucasian, ☐ Chinese, ☐ Filipino, ☐ Hispanic, ☐ Japanese, ☐ Multi-racial, ☐ Native, ☐ Hawaiian, ☐ Pacific Islander, ☐ Other, ☐ Undetermined, ☐ Patient Declines to State

Language: ☐ English, ☐ French, ☐ German, ☐ Japanese, ☐ Korean, ☐ Latin, ☐ Spanish, ☐ Vietnamese, ☐ Patient Declines to State

Ethnicity: ☐ Hispanic or Latino, ☐ Not Hispanic or Latino, ☐ Other or Undetermined, ☐ Patient Declines to State

Employer: (if applicable):_____ **Occupation:** _____

Employment Status: ☐ Full-time, ☐ Part-time, ☐ Housewife, ☐ Unemployed, ☐ Retired

Student Status: ☐ Full-time, ☐ Part-time

Pharmacy Name / Location: _____ **Patient Email Address**: _____

RESPONSIBLE PARTY INFORMATION: (Complete only if different from patient)

Guarantor: _____ **DOB:** _____ **SSN:** _____

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

Home Number: _____ **Cell Number:** _____ **Work Number:** _____

EMERGENCY CONTACT: (someone NOT in your household)

Name: _____ **Relation:** _____

Home Number: _____ **Cell Number:** _____ **Work Number:** _____

INSURANCE INFORMATION:

Primary Insurance Name: _____

Policy #: _____ **Group #:** _____

Name of Insured: _____ **Insured DOB**: _____

Secondary Insurance Name: (complete only if Medicare is primary insurance) _____

Policy #: _____ **Group #:** _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I authorize Powell & Fuselier Medical, PLLC to furnish information to insurance carriers concerning my medical condition and care. I assign to Powell & Fuselier Medical, PLLC all payments for medical services rendered to me or my dependents. I also request payment of government benefits either to myself or the party who accepts assignment. This authorization is valid as long as I am a patient of Scott J. Powell, MD

Any person signing below guarantees payment of the health care costs incurred on behalf of patient and in the event such costs are not incurred on behalf of patient and in the event such costs are not timely paid further guarantee payment of the cost of collection of such bills including attorney fees.

_____ _____

Signature **Date**

The signature is of the: ☐ **Patient** ☐ **Parent of Minor** ☐ **Legal Guardian** ☐ **Patient's power of attorney**

Health Assessment and History

Name: _____ **Date:** _____/_____/_____

DOB: _____/_____/_____ **Age:** _____ **Height:** _____ **Weight:** _____

CHIEF COMPLAINT:

_____---

_____

_____

Primary Care Physician: _____ **Phone:** _____

Home Health Agency: _____ **Phone:** _____

Pharmacy: _____ **Phone:** _____

Current Medications: (Please list prescriptions, over the counter, vitamins, herbs, etc)

Medication / Dosage	**Medication / Dosage**

Allergies: (medication, latex, chemical, food, x-ray dye, etc) **Reaction:**

Have you, or a blood relative, had a reaction to anesthetic? ☐ **Yes** ☐ **No**

If yes, please explain: _____

CURRENT MEDICAL HISTORY: (Please list all previous hospitalizations or operations)

Illness / Condition	**Date**	**Hospital**	**Doctor / Treatment**

SURGICAL / INVASIVE HISTORY:

Illness / Condition	**Date**	**Hospital**	**Type of Anesthesia**

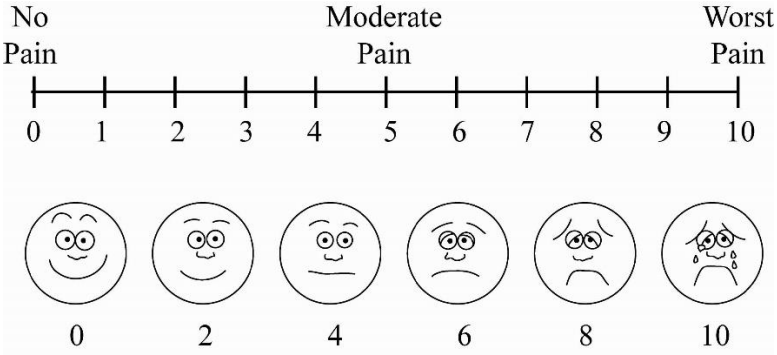
Patient Name: _____ **Date:** _____/_____/_____

Venous Health History

Patient Name: _____ DOB: _____/_____/_____

Do you experience any of the following in your legs?	No	Left	Right	Worst? Comments (optional)
Aching/Pain				
Heaviness				
Tiredness/Fatigue				
Itching/Burning				
Swollen Ankles				
Leg Cramps				
Restless Legs				
Throbbing				
Other				

Your quality of life would be better if what changed with your legs? _____
How many years have you had varicose veins? (circle) 1 2 3+ 5+ 10+ 15+ 20+
What is the pain level in your legs? (circle one)



Have you ever had the following?	No	Left	Right	Comments (optional)
Vein Stripping				
Vein Injections				
Leg Ulcerations				
Blood Clots				
Phlebitis				
Peripheral Artery Disease				

***Activities of Daily Living – Because of your legs, what do you have the <u>most trouble with</u>?**
☐ Preparing Meals ☐ Standing ☐ Stairs ☐ Work ☐ Going to store Other_____

*Do you have a <u>family history</u> of varicose veins? ☐ Yes ☐ No Who?_____
*Do you wear/have you worn <u>compression stockings?</u> ☐ Yes ☐ No How long? _____
*Have your <u>symptoms/worsened</u> in recent months? ☐ Yes ☐ No
*Do you <u>elevate</u> your legs for discomfort? ☐ Yes ☐ No How long? _____
*Do you undergo <u>exercise like walking</u>/strengthening? ☐Yes ☐ No How often? _____

What is the name of your referring physician? _____Phone_____

Consent to Photograph for Communication with Insurance Companies / HIPAA Privacy Policy Acknowledgement

Patient Name: _____ Date: _____

The undersigned authorizes Powell & Fuselier Medical, PLLC to take and reproduce photographs of the above named person in communication with diagnosis, care and treatment. Use of such materials and the person's name is also authorized for use in dealing with the named person's insurance company, including filing claims, medical necessity and appeals with said insurance company.

____ Initial to indicate that you have read, understand and approve authorization as stated above.

I release Powell & Fuselier Medical, PLLC and it physicians, employees and consultants from any liability in connection with the use of such materials. I understand that this authorization will remain effective unless revoked in writing.

Patient Name: _____ Date: _____

Phone Number: _____

Legal Guardians' Signature (if patient is under 18): _____

Witness' Signature: _____ Date: _____

I, _____ have been given the opportunity to read the HIPAA Notice of Privacy Practices of Powell & Fuselier Medical, PLLC.

☐ I want a copy of the HIPAA Privacy Policy

☐ I do not want a copy of the HIPAA Privacy Policy

I have given permission for the office of Powell & Fuselier Medical, PLLC to discuss my medical history / condition with the following person(s):

Name: _____ ☐ Limited Time

_____

_____ ☐ Until Rescinded

Patient's Signature: _____ Date: _____

REVIEW OF SYSTEMS

GASTROINTESTINAL	**YES**	**NO**	**RESPIRATORY**	**YES**	**NO**	**SOCIAL HISTORY**	**YES**	**NO**
ULCERS OR GASTRITIS			ASTHMA			ALCOHOL AMT:		
BLOOD IN STOOLS			WHEEZING			TOBACCO AMT:		
GERD			SHORTNESS OF BREATH			CHEMICAL/ENVIRONMENTAL EXPOSURE		
HEPATIC/RENAL			**CARDIOVASCULAR**					
HEPATITIS			HEART ATTACK/MI			**MUSCULOSKELETAL**		
CIRRHOSIS			CHF			ARTHRITIS		
KIDNEY PROBLEMS			BLEEDING DISORDER			MUSCLE DISEASE		
BLOOD IN URINE			PACEMAKER			PHYSICAL LIMITAITON		
			PAD			CANE/WALKER/WHEELCHAIR		
MENTAL			ANGINA					
ANXIETY						**SKIN**		
DEPRESSION			**ENDOCRINE**			RASH		
			DIABETES			WOUNDS		
VISION			THYROID DISEASE			BRUISES		
BLINDNESS			ADRENAL DISEASE			LESIONS		
CATARACTS						PHYSICAL TRAUMA		
GLAUCOMA			**NEUROLOGICAL**					
GLASSES/CONTACTS			NUMBNESS/TINGLING			**FOR WOMEN**		
			PARALYSIS			# OF PREGNANCIES		
			WEAKNESS			# OR LIVE BIRTHS		
			SEIZURES					
			CVA/STROKE					
			MIGRAINES					