



Pacific Vascular
Access Care, Inc.
Pacific Innovative
Surgery Center, Inc.

Patient Demographic

Last Name: _____ First name: _____ MI: _____

DOB: _____ SS#: _____ Sex: _____ Marital Status: _____

Race: American Indian/Alaskan Native Asian Black or African American Native Hawaiian or Pacific Islander
White Asian Other Decline to state

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Other Decline to state

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Pharmacy Name and Phone number: _____

Primary Care Physician Name and Phone number: _____

Do you have an Advance Directive in place? Yes or No *Please provide us with a copy next visit.

Are you currently in a skilled nursing facility or rehab center? Yes or No

Insurance Information

Primary Insurance: _____ ID #: _____ Grp #: _____

Secondary Insurance: _____ ID #: _____ Grp #: _____

Subscriber Name (if different than patient): _____ Subscriber DOB: _____

Subscriber SS# _____ Subscriber Employer _____

Emergency Contact or Next of Kin

Last Name _____ First Name: _____ Relationship to patient: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____



Contact Information

May we leave a message

On your answering machine/voicemail? **Yes** or **No**

Office/Work Voicemail? **Yes** or **No**

With another Person? **Yes** or **No**

Please list the person(s) with whom we can discuss your protected health information?

Patient Authorization

I authorize the release of any medical information necessary to process any claim. I authorize payment of medical benefits to the physician for services rendered.

Patient Signature: **X** _____ Date: _____

Parent/Guardian Signature (if minor) _____ Date: _____

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature: **X** _____ Date: _____

Parent/Guardian Signature (if minor) _____ Date: _____



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Medical History

Last Name: _____ First Name: _____ DOB: _____

Height: _____ Weight: _____ Allergies: _____

Are you taking any medications including vitamins and supplements? (if so, please list)

Have you ever been diagnosed or treated for the following? (if yes, please specify)

Yes or No Heart Disease or Heart Surgery? _____

Yes or No High blood pressure? _____

Yes or No Shortness of Breath? _____

Yes or No Cancer? _____

Yes or No Diabetes? _____

Yes or No History of Trans Ischemic Attack (TIA) or seizures? _____

Yes or No Kidney/Renal disease? Are you on Dialysis? Yes or No Dialysis Days: Sun, M, T, W, Th, F, Sat

Yes or No Gastrointestinal disease? (stomach, colon, liver, etc.) _____

Yes or No Infectious diseases? (Hepatitis, T.B., AIDS, Lyme) _____

Yes or No Major Surgery? _____

Yes or No Difficulty with healing of wounds? _____

Yes or No History of high cholesterol? _____

Do you have a history of:

Is there a family history:

Asthma? Yes or No

Yes or No

Hives? Yes or No

Yes or No

Eczema? Yes or No

Yes or No

Psoriasis? Yes or No

Yes or No

Skin cancer? Yes or No

Yes or No

Social History: (Please Circle)

Caffeine use: occasionally often not at all

Drink Alcohol: occasionally often not at all

Chew Tobacco: occasionally often not at all

Exercise: occasionally often not at all

Smoke: <1pack a day >1pack a day occasionally do not smoke quit smoking- When: _____

Do you have a need for antibiotics prior to surgery or visiting the dentist? _____

Patient Signature: **X** _____ Date: _____

Relationship to Patient (if applicable): _____



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HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I certain rights to privacy regarding my Protected Health Information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organizations Privacy officer to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are required to agree to my requested restrictions, and if agreed, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (printed): _____

Signature: **X** _____ **Date:** _____

Relationship to Patient: _____

Consent for Evaluation and/or Treatment

By signing below, I am giving my consent to the practice of Malwinder Singha, M.D. for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of any medically recommended diagnostic procedures and/or treatments and given the option to accept or decline.

Patient Name (printed): _____

Signature: **X** _____ **Date:** _____

Relationship to Patient: _____