Total Vascular Surgery, inc
www.TotalVascularSurgery.com

5 Medical Plaza Suite #200 Roseville CA 95661
Tel: (916) 784-1836 Fax: (916) 784-1880

Patient Registration Form

Today's Date:			PCP:		
PATIENT INFORMATION					
Patient's Last Name: First:		Middle:	Marital Status: Married Single Divorced Widowed		
Is this your legal name? Yes ☐ No ☐	If not, what is your legal name?	Former name:	Birth Date:	Age:	Sex: M☐ F☐
Address:	City:	State:	Zip:		
Social Security Number:	Home Phone Number:	Cell Phone Number:			
Occupation:	Employer:	Employer Phone Number:			
Other family members seen here:					

Reason for visit

1. _____

_____

2. _____

_____

3. _____

_____

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone Number:	Cell Phone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize TOTAL VASCULAR SURGERY or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature **Date**

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Health History Questionnaire

(All questions contained in this questionnaire are strictly confidential and will become part of your medical record.)

Original Date: _____
Dates Revised: _____

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Medical History & Diagnosis		
Year		
Surgeries History or Hospitalizations		
Year		

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day? _____					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind? _____					
	How many drinks per week? _____					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day _____	☐ Chew - #/day _____	☐ Pipe - #/day _____	☐ Cigars - #/day _____		
	☐ # of years _____	☐ Or year quit _____				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

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FAMILY MEDICAL HISTORY

MOTHER NAME:_____ DOB:_____ ALIVE/DECEASED:_____ AGE(if alive):_____ ***(Check All That Apply)***		**FATHER NAME:**_____ DOB:_____ ALIVE/DECEASED:_____ AGE(if alive):_____ ***(Check All That Apply)***	
Asthma	YES ☐	Asthma	YES ☐
T/B Lung Disease	YES ☐	T/B Lung Disease	YES ☐
HIV/AIDS	YES ☐	HIV/AIDS	YES ☐
Suicide Attempts	YES ☐	Suicide Attempts	YES ☐
Heart Disease	YES ☐	Heart Disease	YES ☐
High Blood Pressure/Stroke	YES ☐	High Blood Pressure/Stroke	YES ☐
High Cholesterol	YES ☐	High Cholesterol	YES ☐
Blood Disorders/Sickle Cell	YES ☐	Blood Disorders/Sickle Cell	YES ☐
Diabetes	YES ☐	Diabetes	YES ☐
Seizures	YES ☐	Seizures	YES ☐
Mental Illness	YES ☐	Mental Illness	YES ☐
Cancer	YES ☐	Cancer	YES ☐
Birth Defects	YES ☐	Birth Defects	YES ☐
Hearing Loss	YES ☐	Hearing Loss	YES ☐
Speech Problems	YES ☐	Speech Problems	YES ☐
Kidney Disease	YES ☐	Kidney Disease	YES ☐
Alcohol/Drug Abuse	YES ☐	Alcohol/Drug Abuse	YES ☐
Hepatitis/Liver Disease	YES ☐	Hepatitis/Liver Disease	YES ☐
Thyroid Disease	YES ☐	Thyroid Disease	YES ☐
Obesity/Eating Disorder	YES ☐	Obesity/Eating Disorder	YES ☐

OTHER HEALTH CONCERNS

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

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Notice to our patients:

There will be a charge of **$125** for any **Procedure** that is rescheduled, missed or cancelled with less than a **Two (2) Weeks**' notice to our office. We understand that there are certain circumstances when you might not be able to provide the two weeks' notice, for those **valid** circumstance's consideration will be given.

If your Procedure is scheduled within the two-week window, this policy is effective immediately.

We hope you understand that this policy is in place to ensure that you give proper notice to the staff, so they can schedule another patient in that time slot. This is necessary to keep up with the demand for services that Dr. Lim provides.

***I also understand that I am to have a driver drive me home the day of the procedure. I am also to bring my thigh high compression stocking(s) to wear home the day of the procedure. I also understand that I cannot fly for two (2) weeks after the procedure, and if I plan on any long car rides, I must wear my thigh high compression stocking and stop every one (1) or two (2) hours to get out of the vehicle and walk around for at least ten (10) minutes. I also agree to a follow up ultrasound the day after/ one (1) week later, depending on which procedure I am to have, and a two (2) week check up following my procedure/ ultrasound appointments. _____ (Initial)**

Thank you,

Total Vascular Surgery, Inc.

I, _____, have read and agree to the two (2) weeks' notice policy in place at Total Vascular Surgery, Inc. By signing this document, I am agreeing to pay any charges incurred under this policy.

_____ _____

Patient Signature *Date*

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ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILTY

Patient Name:
Chart#:
DOB:

I acknowledge that **I am responsible for any remaining balance owed** to Total Vascular Surgery, Inc. after my insurance has been billed and an EOB (Explanation of Benefits) has been generated for all services rendered by Dr. Lim, including office visits, ultrasound studies, and procedures.

There will be a charge for all appointments rescheduled, missed, or canceled with less than 48 hours notice: ***$40 for an office visit and $50 for an ultrasound***. We understand that there are certain circumstances when it may not be possible to provide 48 hours notice, and these will be given consideration.

I understand that once **I receive a statement in the mail from Total Vascular Surgery, Inc., I have 30 days to pay the balance due in full**. If I am unable to pay the full balance within 30 days, **I will contact the billing office at 1-800-380-9389 to discuss payment options**.

Thank you,

Total Vascular Surgery, Inc.

I, _____, have read and agree to the 48 hour notice policy in place at Total Vascular Surgery, Inc. By signing this document I am agreeing to pay any charges incurred under this policy.

_____ _____

Patient Signature *Date*

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Patient Privacy Consent Form
For Jung J. Lim, D.O.

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also seated in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment and health care operations. When it is appropriate and necessary, we may also make requests for your health care information and information about treatment, payment and health care operations in order to provide health care that is in your best interest

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physicians and not the patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use ·or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse to consent to the use of all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

I have read and received a copy of the Patient Privacy Practices for Jung J. Lim, D.O.

I, _____, give my permission for the staff at Total Vascular Surgery, Inc. to speak

with _____, _____ regarding my medical records.
relationship *name*

Name: _____

Signature: _____

Date: _____