VASCULAR ASSOCIATES OF SAN DIEGO

Vascular & Endovascular Specialists
Board Certified in Vascular Surgery

ACCREDITED FACILITY · IAC INTERSOCIETAL ACCREDITATION COMMISSION · VASCULAR TESTING

Vincent J. Guzzetta, M.D., F.A.C.S. Scott E. Musicant, M.D., F.A.C.S. Thomas T. Terramani, M.D., F.A.C.S.
Patrick R. Cook, D.O., F.A.C.S., R.P.V.I. Luis C. Cajas-Monson, M.D., M.P.H.

PATIENT MEDICAL HISTORY

Date: _____
Height: _____ **Weight:** _____ **Age:** _____

Legal Name: _____
Preferred Name/Nickname: _____
Primary Language: _____
Occupation: _____
Preferred Pharmacy: _____

Medical History:

Please check if you have had: If yes, date:

____ Drastic weight loss or gain _____
____ Severe fever or chills _____
____ Back pain or injury _____
____ Arthritis _____
____ Bleeding tendency _____
____ Hepatitis or HIV _____
____ Diabetes _____
____ Thyroid disorder _____
____ High cholesterol _____
____ Pneumonia _____
____ Asthma or emphysema _____
____ Heart attack _____
____ Chest pain (angina) _____
____ Irregular heartbeat _____
____ High blood pressure _____
____ Stroke _____
____ Lymphedema _____
____ Alcohol addiction _____
____ Drug addiction _____
____ Leg pain when walking _____
____ Phlebitis (vein clot in legs) _____
____ Confirmed COVID-19 _____
____ Other serious medical illness _____

Specify: _____

Allergies: (Medication, tape, latex, iodine, dye?)

_____
_____
_____

Social History:

Do you use alcohol? _____
If yes, how much/how often: _____
_____
Do you/have you ever used tobacco/nicotine products?
(ex: cigarettes, chewing tobacco, vape, hookah, e-cigarettes)
Specify: _____
Amount per day: _____ How many years: _____
If you have quit, when? _____

Family History:

Has anyone in your family had: Who?
Stroke: _____ _____
Heart Attack: _____ _____
Diabetes: _____ _____
Aortic Aneurysm: _____ _____
Varicose Veins: _____ _____

Past Operations and approximate dates:

_____ _____ _____
_____ _____ _____
_____ _____ _____

8860 Center Drive, Suite 450
La Mesa, California 91942

www.VascularSanDiego.com

Tel: (619) 460-6200
Fax: (619) 460-6262

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PATIENT MEDICATIONS

Please list all <u>prescribed and over-the-counter medications</u> that you are currently taking:

Name	Dosage	Frequency

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PATIENT INFORMATION

Name_____ Phone_____
Last First M

Address_____ Alternate Phone_____
Street City State Zip

Birthdate _____ Age_____ Social Security Number_____

Marital Status _____ Sex: M F Ethnicity_____ Declined_____

Email Address:_____

Patient's Employer_____ Work Phone_____

Occupation_____

Spouse or Guardian _____

Spouse's Employer_____ Work Phone_____

Family Physician_____ Referred by_____

Primary Insurance_____ ID#_____

Address_____ Phone_____

Subscriber's Name_____

Secondary Insurance_____ ID#_____

Emergency Contact_____ Phone_____

Address_____ Relationship_____

I hereby authorize and request _____ Insurance Company to assign directly to your physician all payments due for services rendered by said doctor. I understand that I am financially responsible for all charges not covered by insurance.

Signature_____ Date_____

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PATIENT PRIVACY

I have received the Notice of Privacy Practices and have been given an opportunity to review it. This information is available to me at any time upon request.

I understand that my personal health information may be shared with other healthcare providers (ex: physicians, hospitals, etc.) as is necessary.

Patient name:_____ Birthdate:_____

Signature:_____ Date:_____

My personal health information, either verbally or written, may also be released to the following:

(Patients may consider listing family members, caregivers, friends, or other individuals.)

Name: _____ Phone # _____

Relationship: _____

Name: _____ Phone # _____

Relationship: _____

Name: _____ Phone # _____

Relationship: _____

Name: _____ Phone # _____

Relationship: _____

Name: _____ Phone # _____

Relationship: _____

Signature:_____ Date:_____

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April 1, 2023

VASCULAR ASSOCIATES OF SAN DIEGO
CANCELLATION POLICY

To our valued patients:

Please be aware of our 24-hour cancellation policy.

We strive to provide timely healthcare to each of our patients. Because it is difficult to inform other patients of an available appointment without sufficient notice, **missed appointments or same-day cancellation requests will be charged a fee of $50 per appointment.**

If you need to cancel or reschedule your appointment, please call (619) 460-6200 at least 24 hours in advance.

We appreciate your cooperation and understanding.

I hereby acknowledge that I have reviewed Vascular Associates of San Diego's Cancellation Policy and provide my consent to abide by this policy or be charged a fee of $50 for any missed appointments or same-day cancellation requests. I have been advised that a copy of the notice is posted in the reception area and a copy of this acknowledgement will be placed in my chart.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

_____ _____

PATIENT NAME (please print) PATIENT DATE OF BIRTH

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January 1, 2023

VASCULAR ASSOCIATES OF SAN DIEGO
PATIENT NOTICE of THE SUNSHINE ACT & OPEN PAYMENTS

The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) *from* manufacturers of drugs, medical devices, and biologics *to* physicians and teaching hospitals be made available to the public.

This data is published annually in a database known as Open Payments. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. For informational purposes only, the link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided: **https://openpaymentsdata.cms.gov**.

I hereby acknowledge that I have been offered a copy of Vascular Associates of San Diego's Patient Notice of Open Payments. I have been advised that a copy of the notice is posted in the reception area and a copy of this acknowledgement will be placed in my chart.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

_____ _____

PATIENT NAME (please print) PATIENT DATE OF BIRTH

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