# Patient Intake

Name: _____ DOB: _____

SS#:_____ Sex: M F Marital Status: Single, Married, Widowed, Divorced

Preferred Language: _____

Sign Up to Patient Portal: (Circle one) **Yes** **No** Email: _____

Address: _____ City: _____ Zip Code: _____

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

Emergency Contact Name: _____Phone: _____

Emergency Contact Name: _____Phone: _____

**Preferred Pharmacy:** _____

**Preferred Lab Location:** _____

# Insurance Information

Primary Insurance Company: _____ Subscriber ID: _____

Policyholder's Name: _____ Relationship to Patient: _____

Policyholder's SS#: _____ Policyholder's DOB: _____ Policyholder's Phone: _____

Secondary Insurance Company: _____ Subscriber ID: _____

# Medication List

**Medication List:** Please list any medication you have taken in the past 2 weeks

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

***Allergies:** _____

Patient Signature: _____ Date: _____

# Medical History

The following questions regarding your health have been carefully selected as pertinent to your care. Please answer to the best of your ability.

**Patient Name:** _____ **Age:** _____

**Have you ever been diagnosed or treated for: (Please Circle)**

High Blood Pressure  Coronary Disease  Kidney Disease  Diabetes  Stroke  Asthma

Rheumatic Fever  Heart Attack  Hepatitis (A, B, or C)  Peripheral Artery Disease  Valley Fever

Other: _____

**Do you have any reason to believe you may have been exposed to HIV (AIDS)?** (I.e. blood transfusion, drug use, lifestyle) Yes No

**Social History**

**Do you drink alcohol?** Yes No **How often?** _____

**Do you use tobacco?** Yes No **How much?** _____ **Start date?** _____

**History of drug abuse?** Yes No

**Female Only**

**Are you pregnant?** Yes No **Date of last menstrual period?** _____ **Number of Pregnancies** _____ **Births**_____

**Surgical History:** Please list all surgical procedures

| Type of Surgery: | Year: | Facility Name/Doctor: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Patient Signature: _____ Date: _____

## Family History:

**Has anyone in your family members experienced any of the following? (Please Circle)**

Diabetes Heart Trouble High Blood Pressure Gallstones Colon Cancer Breast Cancer Aneurysm
Kidney Disease Other: _____

**Do you or your family have history of Aortic Aneurysm?** Yes No

**If so, when and where was your last imaging done at?** _____

**Do you or your family have history of Carotid Stenosis?** Yes No

**If so, when and where was your last imaging done at?** _____

## Varicose Vein Evaluation:

**Do you experience lower extremity pain?** *Circle one* Yes No **For how long?** _____

**Symptoms:** *Circle*

Burning Itching Heaviness Fatigue Swelling Soreness Bleeding Ulcer Discoloration

**Do you have a personal history of DVT (deep vein thrombosis)?** Yes No

**Do you have active ulcers?** Yes No

**Do you have a family history of varicose veins?** Yes No

**Do you wear compression stockings?** Yes No

**For how long?** _____

**Please describe any history of previous varicose vein treatment?** _____

_____

**How long have you had varicose veins?** _____

**Where are your symptoms worse?** _____

# Dialysis Questionnaire

(Leave blank if it does not portray to you)

**Are you currently on dialysis?** Yes No

**How long have you been on dialysis?** _____

**What days do you currently dialyze?** _____

**Who is your Nephrologist?** _____

**Who is your dialysis center?** _____

**What is your kidney function percentage (GFR)?** _____

**Do you currently have a catheter (CVC)?** Yes No

If yes, which side/how many? _____

**Are you right handed or left handed?** _____

**Do you currently have a Fistula, Graft or PD?** Yes No

If yes, which side/how many? _____

**Do you have a pace maker?** Yes No

# Kern Vascular Center

*"Complete care for arteries and veins"*

4901 Centennial Plaza Way
Phone: (661) 387-8333
Fax: (661) 241-4052

**Review of systems: Circle all that apply**

**Constitutional:** Unexplained weight loss, night sweats, fatigue/malaise/lethargy, sleeping pattern, poor appetite, fever, recent trauma, lumps/bumps/masses, unexplained falls

**Head:** Visual changes, headache, eye pain, double vision, scotomas (blind spots), floaters or "feeling like a curtain got pulled down" (retinal hemorrhage vs amaurosis fugax)

**Ears:** Stuffy ears, ear pain, ringing in ears (tinnitus)

**Nose:** Runny nose, frequent nose bleeds (epistaxis), sinus pain

**Mouth:** Gum bleeding, toothache, sore throat, pain when swallowing (odynophagia)

**Cardiovascular:** chest pain, shortness of breath, exercise intolerance, palpitations, faintness, loss of consciousness, pain or cramps with walking.

**Respiratory:** Cough sputum, wheeze, haemoptysis, shortness of breath, exercise intolerance

**Gastrointestinal:** Abdominal pain, unintentional weight loss, difficulty swallowing (solids vs liquids), indigestion, bloating, cramping, anorexia, food avoidance, nausea/vomiting, diarrhea/constipation, inability to pass gas (obstipation), vomiting blood (haematemesis), bright red blood per rectum (BRBPR, hematochezia), foul smelling dark black tarry stools (melaena), dry heaves of the bowels (tenesmus)

**Genitourinary:** Incontinence, dysuria, hematuria, nocturia, polyuria, hesitancy, terminal dribbling, decreased force of stream, Genital: Vaginal - discharge, pain

**Musculoskeletal:** Pain, misalignment, stiffness, joint swelling, decreased range of motion, crepitus, functional deficit, arthritis.

**Integumentary:** (Skin and/or Breast): Pruritus, rashes, stria, acanthosis nigricans, nodules, tumors, eczema, excessive dryness and/or discoloration.

**Neurological:** Any changes in sight, smell, hearing and taste, seizures, faints, headache, pins and needles (paraesthesia) or numbness, limb weakness, poor balance, speech problems, sphincter disturbance, psychiatric symptoms

**Psychiatric:** Depression, sleep patterns, anxiety, difficult concentrating, body image, work and school performance, paranoia, anhedonia, lack of energy, episodes of mania, episodic change in personality, expansive personality, sexual or financial 'binges'

**Endocrine:** Cold weather preference, mood swings, sweating, diarrhea, irregular menstruation, weight loss, increased appetite, tremors, palpitations, visual disturbances, warm weather preference, slow, tired, depression, thin hair, hoarse voice, heavy periods, constipation, dry skin, excessive thirst, constant urination, polyphagia (constant hunger without gaining weight), more typical in type I diabetes than in diabetes type II, difficulty in treating high pressure, chronic low blood pressure, darkening of the skin without being exposed to the sun, difficulty achieving an erection or sexual arousal

**Hematologic/Lymphatic:** Anemia, easy bruising, prolonged or excessive bleeding after dental extraction/injury, family history of hemophilia, history of a blood transfusion

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**Your Rights -**When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

***Get a copy of your health and claims records:*** You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
***Ask us to correct health and claims records*.** You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
***Request confidential communications***. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
**Ask us to limit what we use or share**. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
**Get a list of those with whom we've shared information.** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
**Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
**Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in payment for your care. Share information in a disaster relief situation. Contact you for fundraising efforts if you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. We never share your information unless you give written permission: Marketing purposes Sale of your information Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.
***Help manage the health care treatment you receive:*** We can use your health information and share it with professionals who are treating you. Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
***Run our organization:*** We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. Example: We use health information about you to develop better services for you.
***Pay for your health services:*** We can use and disclose your health information as we pay for your health services. Example: We share information about you with your dental plan to coordinate payment for your dental work.
***Administer your plan***: We may disclose your health information to your health plan sponsor for plan administration. Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.
***Do research:*** We can use or share your information for health research.
***Comply with the law.*** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
***Respond to organ and tissue donation requests and work with a medical examiner or funeral director:*** We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
***Address workers' compensation, law enforcement, and other government requests:*** We can use or share health information about you: For workers' compensation claims, For law enforcement purposes or with a law enforcement official, With health oversight agencies for activities authorized by law, For special government functions such as military, national security, and presidential protective services
***Respond to lawsuits and legal actions***: We can share health information about you in response to a court or administrative order, or in response to a subpoena.
***Conduct outreach, enrollment, care coordination and case management***: We can share your information with other government benefits programs like Covered California for reasons such as outreach, enrollment, care coordination, and case management.
***Appeal a DHCS decision***: We can share your information if you or your provider appeal a DHCS decision about your health care.
***Apply for full scope Medi-Cal:*** If you are applying for full scope Medi-Cal benefits, we must check your immigration status with the U.S. Citizenship and Immigration Services (USCIS).
Join a managed care plan: If you are joining a new managed care plan, we can share your information with that plan for reasons such as care coordination and to make sure that you can get services on time.
***Administer our programs:*** We can share your information with our contractors and agents who help us administer our programs.
***Comply with special laws***: There are special laws that protect some types of health information such as mental health services, treatment for substance use disorders, and HIV/AIDS testing and treatment. We will obey these laws when they are stricter than this notice. We will never market or sell your personal information.

**Our Responsibilities**
We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. Changes to the Terms of This Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you. DHCS Privacy Officer P.O. Box 997413 MS 4721 Sacramento, CA 95899-7413 Phone: (866) 866-0602 Option 1, or (877) 735-2929 TTY/TTD Fax: (916) 440-7680 Email: privacyofficer@dhcs.ca.gov

Patient Name: (Print): _____Patient Signature: _____ Date:_____

# KERN VASCULAR CENTER

## Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete our information and insurance information prior to seeing the physician(s). Co-pays, deductibles, and non-covered services are due at time of service. We accept cash, checks, and all major credit cards. We may accept assignments of insurance benefits. Your insurance policy is a contact between you and your insurance company. Please be aware that some, and perhaps all of the services provided may be non-covered services.

**Cancellation or rescheduling of a surgery, procedure or office visit: There will be a charge of $100.00 for all surgeries and procedures that are cancelled or rescheduled with less than a 48 hour notice. A charge of $25.00 for a clinic or ultra sound cancellation with in less than 48 hours or no show.** Medicare assignment: If you have **Medicare please sign the following:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to: Dr. Hao D Bui, M.D INC. For any services furnished to me by that physician(s) of supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If other health insurance coverage is indicated in the 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physicians or supplier agrees to accept the changes determination of the Medicare carrier as the full charge and the patient is responsible only for the deductive, co-insurance and non- covered services. Co-insurance and the deductible are based upon the charge determined of the Medicare carrier. I also request payment of government benefits either to myself or the party who accepts assignments below.

**Consent to Release Information:**

I hereby authorize Dr. Hao Bui, M.D. to furnish information to any referring physician, agency, or insurance company I have listed on the patient Information Form.

Patient Signature: _____ Date: _____

**I have read the financial policy and understand and agree to the financial policy.**

Patient Signature: _____ Date: _____

Capacity of Legal Representative, if any: _____

# General Medical Records Release and Authorization for Disclosure of Protected Health Information

Patient Name: _____

DOB: _____ SSN: _____

I authorize the custodian of _____to disclose/release records of the following information:

_____ All records

_____ Labs/Pathology Records

_____ Radiology Records

_____ Doctors Notes

_____ Hospital Records

_____ Prescription Records

_____ Other Records: _____

These records are for services provided on the following dates: _____

Please send the records listed above to:

Name: **KERN VASCULAR CENTER**

Address: **4901 CENTENNIAL PLAZA WAY, BAKERSFIELD, CA 93312**

Phone Number: **661-387-8333** Fax: **661-241-4052**

I further understand that this authorization is voluntary and I may REFUSE to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. By signing below I represent and warrant that I have authority to sign and authorize the use or disclosure of protected health information.

**Signature of patient (Patient Representative):** _____

Date: _____

Printed name of Representative: _____

(I.E parent, guardian, power of attorney for healthcare, executor)