☐ **NEW REGISTRATION** ☐ **UPDATED** ☐

ARIZONA ADVANCED SURGERY, LLC

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #

HOME ADDRESS	CITY	STATE	ZIP	SEX ☐ MALE ☐ FEMALE

HOME PHONE #	EMAIL	CELL PHONE #	MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ OTHER

REFERRING PHYSICIAN NAME AND PHONE NUMBER	PCP NAME & PHONE#

HOW DID YOU HEAR ABOUT US: ☐ PROVIDER REFERRAL ☐ INTERNET ☐ WORD OF MOUTH ☐ PREVIOUS PATIENT ☐ CURRENT PATIENT ☐ BROCHURE ☐ INSURANCE ☐ HOSPITAL ☐ CONCENTRA ☐ MAGAZINE ☐ RADIO ☐ OTHER

MANDATORY-PER NEW CMS GUIDELINES

LANGUAGE	ETHNICITY	RACE
☐ ENGLISH ☐ SPANISH ☐ RUSSIAN ☐ CREOLE ☐ OTHER _____	☐ LATINO/HISPANIC ☐ NON LATINO/NON HISPANIC	☐ ASIAN ☐ NATIVE HAWAIIAN ☐ OTHER PACIFIC ISLANDER ☐ BLACK/AFRICAN AMERICAN ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ WHITE ☐ REFUSE TO REPORT

RESPONSIBLE PARTY INFORMATION (financial responsibility)

LAST NAME	FIRST NAME	MI	HOME PHONE

ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #

EMPLOYER	OCCUPATION	WORK PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

EMERGENCY INFORMATION

NEXT-OF-KIN OR CONTACT INFO –	PHONE

PHARMACY

NAME AND LOCATION	PHONE

INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION

PRIMARY INSURANCE	SUBSCRIBER NAME AND SOCIAL SECURITY	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE

SECONDARY INSURANCE	SUBSCRIBER NAME AND SOCIAL SECURITY	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

ASSIGNMENT OF BENEFITS, FINANCIAL POLICY TERMS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I have read, agree to and signed the Arizona Advanced Surgery's Financial Policy. I agree I will be responsible for any unpaid balances for any reasons

I hereby authorize direct payment to Arizona Advanced Surgery, LLC of any medical benefits payable to me for the services provided at Arizona Advanced Surgery

X_____

Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE

I hereby authorize Arizona Advanced Surgery, LLC to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X_____

Patient Signature or Signature of Guardian or Parent Date

AAS
ARIZONA ADVANCED
SURGERY

Financial Policy Acknowledgment:

Patient Name: _____ **Date of Birth:** _____

Please initial below to acknowledge that you have read our financial policy, which reflects that you as the patient are ultimately responsible for the charges associated with your care.

Initial: _____

Please initial below to acknowledge that you are aware of our appointment cancelation/no-show policy which states:

If 48-hour notice is not given prior to an office appointment, you will be charged a $25 fee.

Initial: _____

If 72-hour notice is not given prior to a scheduled surgery, you will be charged a $250 fee.

Initial: _____

To access our financial policy, please visit our website at ArizonaAdvancedSurgery.com
Or call the office to have a copy sent to you.

Patient Signature: _____ Date:

Staff Signature: _____ Date:

AAS
ARIZONA ADVANCED
SURGERY

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I acknowledge that I have been provided the Arizona Advanced Surgery, LLC Notice of Privacy Practices:

- It tells me how the organization will use my health information for the purpose of my treatment, payment for my treatment and its health care operations.
- The notice explains in more detail how the practice may use and share my health information for purposes other than treatment, payment and health care operations.
- The organization will also use and share my health information as required/permitted by law

Printed Patient Name	Patient's Date of Birth
Signature of Patient	Date
Signature of Client/Personal Representative	Relationship to Patient

☐ **I consent to receive calls from AAS providers/staff for my protected healthcare and other services at the phone numbers provided by myself, including my wireless number I provided. I understand that I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.**

Please list all family member(s)/guardian(s) that may access your medical records and/or financial and billing information. Please List ALL:

Name of Person	Relationship to Patient	Medical Only	Billing Only	Both
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or my legal representative, and delivered to Arizona Advanced Surgery, Attn: HIPAA Compliance Officer, via mail or in person. It will be effective only when Arizona Advanced Surgery actually receives it. The information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

To access our complete Notice of Privacy Practices, please visit our website at ArizonaAdvancedSurgery.com Or call the office to have a copy sent to you.

Vascular Surgery Specialists

Patient History Questionnaire

Please help us be as efficient as possible with your first visit to our program. This health history questionnaire **must** be completed prior to your appointment. Should you need assistance with answers to any of the questions asked, feel free to contact our office and we will be happy to help you. You may fax the completed form to our office prior to your appointment. Health history questionnaires that are incomplete or forgotten at the time of your appointment and/or arriving late for your appointment may result in rescheduling a portion of or your entire appointment.

Patient Name: _____ **Date of Birth:** _____

Reason for your visit: *What is the main reason you are seeing the doctor today?*

_____

_____

_____

Past Medical History: *Have you ever been **DIAGNOSED** with any of the following Problems?*

	No	Yes	Date of Onset	Comments
Cardiovascular				
Do you have a pacemaker	☐	☐	_____	_____
High Cholesterol	☐	☐	_____	_____
High Blood Pressure	☐	☐	_____	_____
Heart Attack	☐	☐	_____	_____
Blood Clots	☐	☐	_____	_____
Other Heart Problems	☐	☐	_____	_____
Respiratory				
Asthma	☐	☐	_____	_____
COPD	☐	☐	_____	_____
Emphysema	☐	☐	_____	_____
Pneumonia	☐	☐	_____	_____
Tuberculosis	☐	☐	_____	_____

PAST MEDICAL HISTORY (Continued)

	No	Yes	Date of Onset	Comments
Endocrine				
Diabetes	☐	☐		
Insulin Dependent (Type I)	☐	☐		
Non-Insulin Dependent (Type II)	☐	☐		
Thyroid Disorder	☐	☐		
Adrenal Disorder	☐	☐		
Other Endocrine	☐	☐		
Gastrointestinal				
Liver Disorder	☐	☐		
Stomach Problems	☐	☐		
Kidney				
Kidney Disorder	☐	☐		
Currently on Dialysis	☐	☐		
Mental and Emotional				
Depression (requiring treatment)	☐	☐		
Anxiety (requiring treatment)	☐	☐		
Drug Dependency	☐	☐		
Alcohol Dependency	☐	☐		
Neurologic				
Epilepsy	☐	☐		
Fainting	☐	☐		
Dizziness	☐	☐		
Stroke	☐	☐		
Hematologic/Immunity				
Anemia	☐	☐		
HIV/AIDS	☐	☐		
Syphilis	☐	☐		
Cancer				
Please indicate type:	☐	☐		
Injuries				
Please List:	☐	☐		
Other Not Listed Above				
Problem:	☐	☐		

ALLERGIES:

☐ No Known Drug Allergies

Allergen	Reaction	Allergen	Reaction
Aspirin	No Yes _____	Latex	No Yes _____
Codeine	No Yes _____	Adhesive Tape	No Yes _____
Morphine	No Yes _____		
Penicillin	No Yes _____	Other.....	
Sulfa	No Yes _____	_____	No Yes _____
Warfarin/Coumadin	No Yes _____	_____	No Yes _____
Any other Drug…			
_____	No Yes _____		
_____	No Yes _____		
_____	No Yes _____		

☐ No Known Food Allergies

FAMILY HISTORY: *Please list any medical problems in your relatives.*

☐ Family Medical Unknown

	Not Present	Mother	Father	Sister(s)	Brother(s)
Cancer - Type:					
Deep Vein Thrombosis (DVT)					
Clotting Disorder					
Aneurysms					
Peripheral Arterial Disease					
Stroke					
Transient Ischemic Attack					
Varicose Veins					
Heart Disease Type: _____					

Other Conditions:

SOCIAL HISTORY:

Tobacco Use: ☐ Never ☐ Former Smoker – When did you stop? _____ ☐ Smoker – Packs per day? ____

Alcohol Use: ☐ Never ☐ Rarely ☐ Socially ☐ Occasionally ☐ Moderate ☐ Rarely

How much? _____

Drug Use: ☐ Never ☐ Type and frequency _____

Please enter the date for the last time you had any of the following

Mammo _____ Pap Smear _____ Colonoscopy _____ Flu Shot _____ Pneamovax _____

MEDICATIONS: *Please list any medication including aspirin, vitamins, over-the-counter, or herbal medication.*

Medication Name	Dose	Frequency (How Often Taken)

PAST SURGICAL HISTORY:

Year	Procedure	Surgeon

ANESTHESIA HISTORY:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ No ☐ Yes

If **YES**, Please indicate which type of anesthesia and check reaction(s) below:

Type	Reaction
General Anesthesia	☐ No Problems ☐ Nausea ☐ Vomiting ☐ Slow Awakening ☐ Difficult Intubation ☐ Other
IV Sedation	☐ No Problems ☐ Nausea ☐ Vomiting ☐ Slow Awakening ☐ Other
Epidural/Spinal	☐ No Problems ☐ Nausea ☐ Vomiting ☐ Bleeding ☐ Headache ☐ Other
Regional Block	☐ No Problems ☐ Insufficient ☐ Prolonged ☐ Systemic Reaction ☐ Other
Local	☐ No Problems ☐ Insufficient Block ☐ Heart Palpitations ☐ Systemic Reaction ☐ Other

REVIEW OF SYSTEMS

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Please place a check mark in the box next to any **current symptoms** you are experiencing

General
- ☐ Fevers
- ☐ Migraines

Skin of Extremities
- ☐ Loss of hair on legs/arms
- ☐ Discoloration of legs
- ☐ Toenail changes
- ☐ Discoloration of toes
- ☐ Ulcers of legs
- ☐ Varicose Veins
- ☐ Rash
- ☐ Cold Skin
- ☐ Bruising
- ☐ Burning

Head and Neck
- ☐ Blurred Vision

Respiratory
- ☐ Shortness of breath

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Previous heart attack
- ☐ Blood clots
- ☐ Leg pain while exercising
- ☐ Swelling of extremities
- ☐ Elevated blood pressure

Gastrointestinal
- ☐ Abdominal pain
- ☐ Abdominal mass

Musculoskeletal
- ☐ Muscle weakness
- ☐ Pain in extremities
- ☐ Muscle cramps
- ☐ Difficulty in walking

Neurological
- ☐ Dizziness
- ☐ Previous Stroke
- ☐ Decreased memory
- ☐ Sensation loss
- ☐ Headaches
- ☐ Tremor
- ☐ Seizures
- ☐ Numbness
- ☐ Tingling

Endocrine
- ☐ Appetite changes

Hematology
- ☐ Prolonged bleeding

Genitourinary-Male only
- ☐ Impotence