Denton Vascular Lab, Inc.

Patient Name: _____ **Date of birth:** _____

Referring Doctor (new visits only):

_____

Reason for Visit:

_____

HISTORY

Please circle all that apply. When you cannot find your diagnosis or surgery in the list, feel free to write in under the appropriate system or anywhere on the page if unsure.

Past Medical History

- I have no significant medical history.

Neurologic:
- Alzheimer's, brain tumor, cerebral AVM, cerebral artery aneurysm, dementia, headache syndrome, hemiplegia, migraine headaches, multiple sclerosis, neuropathy, Parkinson's disease, restless leg syndrome, seizure disorder, stroke syndrome, transient ischemic attack/TIA, traumatic brain injury, other _____

Head, Eyes, Ears, Throat:
- Cataract, deafness, glaucoma, hearing loss, blindness, other _____

Respiratory:
- Asthma, COPD, oxygen dependent, sleep apnea, other _____

Cardiovascular:
- Aortic aneurysm/AAA, iliac aneurysm, thoracic aortic aneurysm/TAA, other arterial aneurysm, aneurysm of vein, atrial fibrillation, carotid artery stenosis, congestive heart failure/CHF, coronary artery disease, DVT, hyperlipidemia, hypertension, lymphedema, murmur, heart attack/MI, peripheral artery disease, pulmonary embolism, valvular heart disease, varicose veins, venous insufficiency, other _____

Renal/Kidney:
- Chronic renal failure, ESRD/dialysis, nephrosclerosis, renal artery stenosis, other _____

Denton Vascular Lab, Inc.

Past Medical History (cont.)

Gastrointestinal/Abdominal:

- Celiac disease, cirrhosis, Crohn's disease, diverticulitis, esophageal reflux/ GERD, gallbladder disease, hepatitis, irritable bowel syndrome/IBS, mesenteric artery stenosis, other _____

Urologic/Gynecologic:

- Prostate hypertrophy, chronic urinary tract infection, urologic/gynecologic diagnosis _____

Dermatologic/Skin:

- Dermatitis, psoriasis, other _____

Rheumatologic:

- Rheumatoid arthritis, lupus, Sjogren's syndrome, other _____

Infectious disease:

- AIDS, HIV, Lyme disease, other _____

Musculoskeletal/Orthopedic:

- Amputation: _____ chronic pain syndrome, gout, degenerative disc disease, low back pain, osteoarthritis, osteoporosis, other _____

Endocrine:

- Hyperthyroidism, hypothyroidism, thyroid nodule, type 1 diabetes, type 2 diabetes, obesity, _____

Oncologic/Cancer:

- Breast cancer, colon cancer, kidney cancer, lung cancer, skin cancer, prostate cancer, other _____

Hematologic/Blood disorders:

- Anemia, thrombocytopenia, bleeding disorder, other _____

Psychiatric:

- Bipolar disorder, anxiety disorder, ADHD, depression, schizophrenia, alcoholism, other _____

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Past Surgical History

o **I have no significant surgical history.**

(Circle all that apply)

Carotid Surgery:

o Carotid angiogram, carotid bypass surgery, carotid endarterectomy, vertebral artery angiogram, other _____

Arterial intervention of the leg:

o Angiogram of the right leg, angiogram of the left leg, bypass surgery of the right leg, bypass surgery of the left leg, other _____

Other arterial procedures:

o Arterial embolectomy or thrombectomy, endovascular repair of aortic aneurysm/EVAR, open repair of aortic aneurysm, renal artery angiogram, mesenteric/celiac artery angiogram, other_____

Venous procedures/treatments:

o Venous intervention/treatment of the right leg, venous intervention/treatment of the left leg, cosmetic sclerotherapy, venous thrombectomy, venogram, other _____

Dialysis access/maintenance:

o AV fistula, AV graft, peritoneal dialysis/ PD catheter, fistulogram with intervention, revision of fistula/graft, thrombectomy of fistula/graft, fistula aneurysm repair, other _____

Cardiac:

o Heart catheter, defibrillator, heart bypass/CABG, heart stent, pacemaker, other_____

Pulmonary:

o Pneumonectomy, other_____

Gastrointestinal/Abdominal:

o Appendectomy, cholecystectomy. Gallbladder, colostomy, gastric bypass/banding, hernia repair, colectomy, other _____

Head, Eyes, Ears, Throat:

o Cataract, partial thyroidectomy, total thyroidectomy, parathyroid surgery, tonsillectomy, other _____

Neurosurgery:

o Brain surgery, vagal nerve stimulator placement, other_____

Orthopedic:

o Amputation, carpal tunnel syndrome, hip replacement, knee replacement, other knee surgery, low back surgery, rotator cuff repair, shoulder surgery, spinal surgery, other _____

Denton Vascular Lab, Inc.

SPECIAL FASTING INSTRUCTIONS

If you are scheduled for:

RENAL (Kidney) DUPLEX ABDOMINAL DUPLEX MESENTERIC DUPLEX

- Eat a light meal for dinner the evening before your testing. NO GASSY FOODS!

Foods to Avoid

Milk, Ice Cream, Yogurt, Apples, Peaches, Prunes, Pears, Onions, Peppers, Broccoli, Cauliflower, Cabbage, Brussel Sprouts, Beans, Spicy Foods, Wheat or Oat Breads, Cereal, Carbonated Drinks, Chewing Gum, Hard Candy, and Smoking

- Nothing to eat after dinner, clear liquids till midnight (evening/night time medication taken with water).

The morning of the study:

* No gum…No mints…No smoking!
* You may take your normal morning meds with sips of water.
* Please arrive 15 minutes early to complete paperwork for testing.
* The technician **DOES NOT** give patient test results! You must get your results from the ordering physician.
* Failure to follow the above instructions may result in an inadequate test and may need to be rescheduled. Please call the office if you have any questions.

DENTON VASCULAR LAB, INC.

3322 COLORADO BLVD. SUITE 102
DENTON, TX 76210

Patient Last Name	First Name	Middle Name	Age

Mailing Address	City	State	Zip	Home Phone #

Date of Birth	Social Security #	Marital Status	Sex	Cell Phone #

Employer	Occupation	Work Phone #

Emergency Contact Name	Relationship to Patient	Phone #

If insurance is not in patient's name (e.g.: under the patient's spouse's/parent's name) please fill out the following information about the **Policyholder**:

Name of Policyholder	Date of Birth	SS #

Relationship to Patient	Employer	Work Phone #

Financial Responsibility: By my signature below, I acknowledge that I am personally responsible for fees charged for medical service regardless of my insurance coverage.

Denton Vascular Lab, Inc. bills for the performance of the diagnostic exam(s) done today. Surgery Associates of North Texas bills separately for the diagnostic interpretations provided by their vascular surgeons.

Please contact Surgery Associates of North Texas (940-387-7588) for any questions regarding insurance or billing for the interpretation of your diagnostic exam(s).

_____
Initial here.

Consent for Exam: By my signature below, I voluntarily consent to the medical procedure and understand the procedure is diagnostic in nature.

Insurance Authorization and Assignment: By my signature below, I hereby authorize that payment by authorized Medicare/other insurance company benefits be made on my behalf to Denton Vascular Lab, Inc. for any services furnished to me by the party who accepts assignment. Regulations pertaining to Medicare assignment of benefit apply.

Release of Protected Health Information: By my signature below, authorization is hereby granted to release my medical or other information to my listed insurance carriers for processing my claim.

Patient Signature	Date

DENTON VASCULAR LAB, INC.

3322 COLORADO BLVD. SUITE 102
DENTON, TX 76210

HIPAA Information and Consent Form

Patient Name _____ Date of Birth _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). Examples of PHI are a patient's name, address, phone numbers, date of birth, or medical diagnoses. The Notice of Privacy Practices provided by Denton Vascular Lab, Inc. describes such uses and disclosures more completely.

Patient privacy has always been important to Denton Vascular Lab, Inc.
We have adopted the following policies:

- Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers and insurance payers as is necessary and appropriate for your care.

- Denton Vascular Lab, Inc. uses paper charts. In the normal course of providing care, patient folders may be present, at least temporarily, in the technologists workspace or an exam room. Those records will not be available to persons other than office staff.

- Denton Vascular Lab, Inc. contacts patients for appointment reminders, to clarify insurance information, or to communicate regarding account status. We may do this by telephone, e-mail, or U.S mail (in the form of account statements), as is convenient for the practice and/or as requested by you.

- We agree to provide patients with access to their records in accordance with state and federal laws.

You have the right to review the Notice of Privacy Practices prior to signing this consent.
Denton Vascular Lab, Inc. reserves the right to revise its Notice of Privacy Practices at any time in order to better serve the needs of both the facility and the patient. A revised Notice of Privacy Practices may be obtained by forwarding a written request to this organization.

You have the right to request that Denton Vascular Lab, Inc. restrict how it uses or discloses your protected health information and to request change in certain policies used within the facility concerning your PHI. However, we not obligated to alter internal policies to conform to your requests.

You may revoke your consent in writing except to the extent that the practice has already made disclosures in reliance upon your prior consent.

By signing this form, I hereby give my consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and that I have been give the opportunity to review Denton Vascular Lab's Notice of Privacy Practices.

_____
Signature of Patient or Legal Guardian Date

_____
Printed name of Patient or Legal Guardian.

DENTON VASCULAR LAB, INC.

3322 COLORADO BLVD. SUITE 102
DENTON, TX 76210

Patient Name _____ Date of Birth _____

Communication Consent: We may occasionally need to communicate with your family regarding medical and/or billing information. Please **initial** the appropriate blanks below.

_____ It is okay to speak to my **spouse**.

_____ It is okay to speak to my **parent/child**.

_____ Speak only to me.

_____ It is okay to leave a message on my **home** voice-mail/answering machine.

_____ It is okay to leave a message on my **cell phone** voice-mail.

_____ It is okay to leave a message on my **work** voice-mail/answering machine.

_____ It is okay to contact me via **email**: _____
(We only email information when you request it.)

Please list names of people we may speak to:

_____

_____

We collect the following information on behalf of Surgery Associates of North Texas which bills separately for the interpretation of our exams.

RACE:

- ☐ **Decline**
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other _____

ETHNICITY:

- ☐ **Decline**
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

PREFERRED LANGUAGE:

- ☐ **Decline**
- ☐ English
- ☐ Spanish
- ☐ Other _____

Patient Signature _____ Date _____