Pacific Coast Vascular & General Surgery, Inc.

MARC M SEDWITZ MD FACS • SUNIL S RAYAN MD FACS • RAE L RICHARD CRNP

General • Vascular • Endovascular • Laparoscopic • Trauma • Venous

Name:____ **Date of Birth:**____________________

Referred by:____

We sincerely appreciate you taking the time to complete the following questions before seeing the doctor. This information will greatly facilitate your visit and is essential for our records. PLEASE BRING THIS FORM WITH YOU.

***Chief Complaint**: List the complaint(s) which have led you to seek medical help and when they began.*

____

____

Past Surgical History:

Operation _______________ *Hospital/City* _______________ *Date* _______________

____

____

____

____

*Have you ever been seriously injured? If so, explain:*____

____

List All Medical Conditions for Which You See or Have Seen a Doctor:

Medical Condition _______________ *Doctor Seen* _______________ *Date* _______________

____

____

____

____

____

List, Date and Explain Any Recent Hospitalizations Not Already Listed:

Reason for Hospitalization _______________ *Hospital City/State* _______________ *Date* _______________

____

____

____

____

Please Indicate if You Had any of the Following:

[ ] Heart Attack________________________________

[ ] Chest Palpitation____________________________

[ ] Chest Pain/Shortness of Breath________________

[ ] High Blood Pressure__________________________

[ ] Lung Disease/Pneumonia______________________

[ ] Diabetes____________________________________

[ ] Asthma/Lung Problems________________________

[ ] Intestinal Bleeding___________________________

[ ] Urinary Burning/Frequency_____________________

[ ] Cancer______________________________________

[ ] Gastrointestinal Complaints____________________

[ ] Hepatitis/Jaundice___________________________

[ ] Substance Abuse_____________________________

[ ] Kidney Failure_______________________________

[ ] Stroke/Mini-Stroke___________________________

[ ] Arthritis/Gout_______________________________

[ ] Weight Loss_________________________________

[ ] Skin Conditions/Rash_________________________

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Name:____

Please list all medications you are now taking. Please include aspirin, pain medications, hormones, contraceptives and vitamins.

Name of Medicine	*Dose*	*How Often*	*Date Began*

Please list all medication Allergies:

	Yes	*No*	*Type of Reaction*
Penicillin	[ ]	[ ]	
Sulfa	[ ]	[ ]	
Iodine	[ ]	[ ]	
Other			

Social History: Tobacco & Alcohol:

*Ever smoke?*______*If Yes, for how long?*________*How many packs per day?*_________*When started?*______*When stopped?*_______

*Do you consume alcohol beverages?*____________________*If so, how many drinks per day?* ____________________

Personal History:

*Place of Birth?*______________________________*How long have you lived in California?*________________________

What type of work do you do? ____

Are you married [ ] divorced [ ] widowed [ ] *Number of children?*____________________________

Family History: Please give the following information about the health of your immediate family.

Relation	*Age*	*Medical Problems*	*State of Health*
Mother			
Father			
Siblings			
Siblings			
Children			

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General Information

Last Name:____First:_________________________Middle:_____

Date of Birth:________________Age:____________ Sex: [ ] M [ ] F Marital Status: _________________

Street Address: City/State: Zip: Home Number:

____( )_____________________

Mailing Address:

____

Employer: Occupation (indicate if student): How Long: Work Number:

____( )_____________________

Employer Address: City/State: Zip:

____

Social Security #: Drivers License #: State of Issue:

____

Responsible Party for Payment of Services

Guarantor Name: Self [ ] Spouse [ ] Other [ ]

Street Address: City/State: Zip: Home Number:

____( )_____________________

Employer's Name: Occupation: How Long: Work Number:

____( )_____________________

Employer's Address: City/State: Zip:

____

Spouse/Parent Information: (Parent information if patient is a minor or student)

Spouse/Parent's Name: Spouse/Parent's Social Security Number:

____

Employer's Name: Occupation: How Long: Work Number:

____( )_____________________

Employer's Address: City/State: Zip: Home Number:

____( )_____________________

Nearest Relative/Emergency Contact: (If same as Spouse/Parent Info Check Here) → [ ]

Emergency Contact Phone:____

Other Contact Name: ____________________________________ Relationship: ___________________________

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Name:____

Patient Referral Information: Please Check Indicate How You Were Referred to Our Office.

Referring Doctors Name:________________________________Medical Specialty:___________________________

Friend/Relative Name:________________________________ Was this person a previous patient? [ ]Yes [ ]No

Insurance Company Name of Provider Directory:____

Referred by Scripps Memorial Hospital [ ] Health Care Finder [ ] Emergency Room [ ] Trauma [ ] Staff Member [ ] Other/indicate:________________

Name of Your Primary Care Physician:________________________________Telephone:________________________

Insurance Information:----Primary	
Primary Insurance Company:	Group Number or Policy Number:
Address/City/State/Zip	Telephone Number:
	( )
Subscriber/Policy Holder:	Subscriber's Social Security #:
Medicare Identification Number:	

Insurance Information:----Secondary	
Secondary Insurance Company:	Group Number or Policy Number:
Address/City/State/Zip	Telephone Number:
	( )
Subscriber/Policy Holder:	Subscriber's Social Security #:
Medicare Identification Number:	

Kindly Present Your Insurance Card(s) to Reception Upon Check-In and Payment for Your Required Co-Pay Amount

Medical Information Authorization for Release

I hereby authorize Pacific Coast Vascular & General Surgery, Inc. to furnish my medical information to insurance carriers concerning my medical and surgical care. In addition, I hereby irrevocably assign to Pacific Coast Vascular and General Surgery, Inc., all payments for medical and surgical services rendered. In the event that an insurance claim is filed on my behalf, I authorize payment to be made directly to Pacific Coast Vascular and General Surgery, Inc.

Patient or Responsible Party Signature:____________________________________ Date:__________________