MIAMI VASCULAR SPECIALIST

PATIENT HISTORY

Date:_____

Name:_____ **Wt.**_____ **Ht.**_____ **Age** _____ **Birthdate** _____

Nombre:_____ Peso_____ Estatura_____ Edad _____ Fecha _____

Nacimiento _____

EMAIL ADDRESS:_____

CORREO ELECTRONICO:_____

Phone number/Numero de telefono:_____

Present complaint or illness: _____

De que se queja:_____

Have you ever had surgery? Y/N List: 1)_____ **2)**_____

Ha Tenido cirugia previa? Si/No 1)_____ 2)_____

3)_____ 4)_____

Cancer: Y/N _____ **Diabetes: Y/N** _____ **Stroke: Y/N** _____

Cancer: Si/No _____ Diabetis: Si/No _____ Embolia Cerebral: Si/No _____

Heart Problems: Y/N: _____

Problema del Corazon: Si/No:_____

High Blood Pressure: Y/N _____ **Other Serious Disease: Y/N**_____

Presion Alta: Si/No:_____ Otras Complicaciones de Salud: Si/No _____

If yes, What? _____

Cuales son? _____

Have you ever been hospitalized? Y/N _____ **If yes, Why?**_____

Ha estado internado: Si/No: _____

_____

Any Medical Allergies? Y/N _____ **If yes, to what?**_____

Alergias a Medicinas? Si/No _____ A que?_____

Names and dose of known medications: Nombres y dosis de las medicinas que toma:

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

How do your veins bother you?		Le molestan sus venas?	
Sharp Pain:	____Yes ____No	Dolor Fuerte:	____Si ____No
Congestion/Pressure: Y/N	____Yes ____No	Presion:	____Si ____No
Swelling: Y/N	____Yes ____No	Inflamacion:	____Si ____No
Itching: Y/N	____Yes ____No	Picazon:	____Si ____No
Appearance: Y/N	____Yes ____No	Apariencia:	____Si ____No
Bleeding: Y/N	____Yes ____No	Sangramiento:	____Si ____No

Do you have any of these problems?		Tiene algun de estos problemas?	
CARDIOVASCULAR: (check yes or no)			
Chest pain/Angina in past 6 mo.	____Yes ____No	Dolor de Pecho:	____Si ____No
Shortness of Breath w/ walking:	____Yes ____No	Falta de Aire al caminar:	____Si ____No
Shortness of Breath Lying down:	____Yes ____No	Falta de Aire al acostar:	____Si ____No
Heart Failure:	____Yes ____No	Insufisiencia cardiaco:	____Si ____No
Heart Murmur:	____Yes ____No	Soplo cardiaco:	____SI ____No
Palpitations or Irregular Heartbeat	____Yes ____No	Palpitaciones:	____Si ____No
Swelling of Feet or Legs:	____Yes ____No	Edema de las piernas:	____Si ____No
Leg Pain with Walking:	____Yes ____No	Dolor al caminar:	____Si ____No
NEUROLOGIC:			
Stroke:	____Yes ____No	Embolia cerebral:	____Si ____No
Mini-stroke or TIA	____Yes ____No	Ataque de isquemia transitoria	____Si ____No
Sciatica:	____Yes ____No	Siatica:	____Si ____No
Fainting Spells:	____Yes ____No	Desmayo	____Si ____No
Convulsions or Seizures	____Yes ____No	Convulsiones	____Si ____No
NEUROPATHY:			
Numbness in legs:	____Yes ____No	Piernas dormidas	____Si ____No
Pins and Needles in Hands	____Yes ____No	Alfileres en las manos	____Si ____No
Pins and Needles in Feet:	____Yes ____No	Alfileres en los pies	____Si ____No
GENITOURINARY:			
Pain on urination:	____Yes ____No	Dolor al Orinar	____Si ____No
Burning on Urination	____Yes ____No	Ardentia Al orinar	____Si ____No
Impotence	____Yes ____No	Impotencia	____Si ____No
Frequent Urinating	____Yes ____No	Orinar frequentemente	____Si ____No
Do you have blood in urine now?	____Yes ____No	Tiene sangre en el orine	____Si ____No
ENDOCRINE:			
Gout:	____Yes ____No	Gota	____Si ____No
Overactive Thyroid:	____Yes ____No	Tiroide alterado	____Si ____No
Underactive Thyroid:	____Yes ____No	Tiroide lento	____Si ____No
Diabetes:	____Yes ____No	Diabetis	____Si ____No
GYNECOLOGICAL:			
Are you Pregnant?	____Yes ____No	Esta embarazada	____Si ____No
Are you taking Birth Control Pills?	____Yes ____No	Toma pastillas anticonceptivas	____Si ____No
Are you taking hormones:	____Yes ____No	Toma hormonas femeninas	____Si ____No
GASTROINTESTINAL:			
Stomach Ulcer:	____Yes ____No	Ulcera del estomago	____Si ____No
Vomiting Blood	____Yes ____No	Vomita Sangre	____Si ____No
Hiatus Hernia	____Yes ____No	Hernia hiatal	____Si ____No
Heartburn or Indigestion	____Yes ____No	Indigestion	____Si ____No
Gallbladder Disease	____Yes ____No	Piedras en la vesciula	____Si ____No
Liver Trouble	____Yes ____No	Problemas de higado	____Si ____No
Black Stools	____Yes ____No	Heces Fecales oscuro	____SI ____No
Recent Change in Bowel Habits	____Yes ____No	Cambio reciente en evacuacion	____Si ____No
Bleeding with Bowel Movements	____Yes ____No	Sangramiento en heces fecales	____Si ____No
Hemorrhoids	____Yes ____No	Hemorroides	____Si ____No

Frequent Diarrhea	____Yes ____No	Diarrhea	____Si ____No
Abdominal Pain	____Yes ____No	Dolor abdominal	____Si ____No
Weight Gain	____Yes ____No	Aumento de peso	____Si ____No
Weight Loss	____Yes ____No	Perdida de peso	____Si ____No

HEAD - EARS - EYES - NOSE - THROAT:

Chronic Sinus Trouble	____Yes ____No	Problema de sinositis	____Si ____No
Impaired Hearing	____Yes ____No	Sordera	____Si ____No
Dizziness	____Yes ____No	Mareo	____Si ____No
Temporary Spells of Blindness	____Yes ____No	Cequera Pasajera	____Si ____No
Double Vision	____Yes ____No	Vision Doble	____Si ____No
Glaucoma	____Yes ____No	Glaucoma	____Si ____No
Cataracts	____Yes ____No	Cataratas	____Si ____No

RESPIRATORY:

Spitting Up Blood	____Yes ____No	Espectora Sangre	____Si ____No
Chronic or Frequent Cough	____Yes ____No	Tos Frecuente	____Si ____No
Asthma	____Yes ____No	Asma	____Si ____No
Pneumonia	____Yes ____No	Pulmonia	____Si ____No
Tuberculosis	____Yes ____NO	Tuberculosis	____Si ____No

BLOOD PROBLEMS AND BLEEDING:

Do You Heal Cuts Slowly?	____Yes ____No	Sana lentamente sus heridas	____Si ____No
Anemia/Blood Diseases	____Yes ____No	Anemia	____Si ____No
Excessive Bleeding with Surgery	____Yes ____No	Sangramiento Excesivo durante cirugia	____Si ____No
Abnormal Bruising or Bleeding	____Yes ____No	Amoratamiento de la piel	____Si ____No
Phlebitis or Blood Clots in Veins	____Yes ____No	Flebitis on las venas	____Si ____No

ANY OTHER BLOOD DISORDERS

Sickle Cell Anemia	____Yes ____No	Anemia Falciforme	____Si ____No
HIV	____Yes ____No	HIV	____Si ____No
Hepatitis	____Yes ____No	Hepatitis	____Si ____No
Chlamydia	____Yes ____No	Clamidia	____Si ____No
Gonorrhea	____Yes ____No	Gonorrea	____Si ____No
Syphilis	____Yes ____No	Siphillis	____Si ____No

_____

Patient Signature/Firma del Paciente

MIAMI VASCULAR SPECIALISTS

PATIENT INFORMATION

EMPLOYER: _____

Lugar de Empleo: _____

Employer Phone Number: _____

OCCUPATION: _____

Ocupacion: _____

NEAREST RELATIVE: _____

Nearest relative home phone: _____

Pariente mas cercano: _____

Telefono de pariente mas cercano: _____

WHO REFERRED YOU TO OUR OFFICE: _____

Quien le refiro a nuestra oficina: _____

LIST ANY ALLERGIES OR CONDITIONS: _____

Alergias o condiciones: _____

DO YOU SMOKE? _____ PRIMARY LANGUAGE: _____

Usted Fuma? _____ **Idioma Principal:** _____

HISTORY OF ALCOHOL OR SUBSTANCE ABUSE? _____

Historia de alcohol or sustancia daninas?

_____

MIAMI VASCULAR SPECIALISTS

FINANCIAL AGREEMENT

THE UNDERSIGNED agrees, whether he/she signs as guardian, agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the physician(s).

Should the account be referred to an attorney for collection, the undersigned shall pay responsible attorney's fees and collection expenses.

_____
Print Patient's Name

Date:_____ _____
Patient Signature

Date:_____ _____
Patient's agent or guardian

CONVENIO FINANCIAL

EL SUSCRITO esta de acuerdo, tanto el como ella, en firmar como guardianes del paciente y hacerse cargo de los honorarios del medico:

_____
Nombre Del Paciente

Fecha: _____ _____
Firma Del Paciente

Fecha _____ _____
Guardian o Agente Del Paciente

Acknowledgement of Receipt of Miami Vascular Specialists Notice of Privacy Practices

I,_____(printed name) have received Miami Vascular Specialists Notice of Privacy Practices.

Signature: _____

Date:_____

If patient or patient's representative refuses to sign acknowledgement of receipt of Notice of Privacy Practices, please document the date and time the Notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

Privacy Officer's Acknowledgement: _____

Miami Vascular Specialists

Vascular and General Surgery
8950 N. Kendall Drive - #504-W
Miami, FL 33176
Phone: 305-274-2030
Fax: 305-279-0878

Howard E. Katzman, M.D., F.A.C.S.
Abilio A. Coello, M.D., F.A.C.S.
Ignacio Rua, M.D., F.A.C.S.
Athanassios I. Tsoukas, M.D., F.A.C.S.
Libby Watch, M.D., F.A.C.S.
Michele L. Taubman, M.D.

AUTHORIZATION FOR CREDIT CARD PAYMENT

PATIENT NAME: _____

SGM ACCOUNT NUMBER: _____

I authorize The Surgical Group of Miami to charge to my credit card listed below the amount of: $_____ as payment towards my account.

TYPE OF CREDIT CARD (CHECK ONE)

_____ **Master Card**

_____ **Visa**

_____ **American Express**

_____ **Discover Card**

CREDIT CARD #: _____

Expiration Date: _____ **Code:** _____

Amount to be charged: _____

Please check: _____ **One time charge** _____ **Monthly until paid in full**

Signature: _____ **Date:** _____

Daytime Telephone: _____

Miami Vascular Specialists

Sample of Participating Insurance Companies

AVMED – with AUTHORIZATION

AETNA – PPO……..HMO – with AUTHORIZATION (OPEN ACCESS NOT NEEDED)

BC/BS – PPO

BLUECARE HMO – with AUTHORIZATION

CIGNA

GHI

HUMANA – PPO ……..HMO – with AUTHORIZATION

MEDICARE

MEDICA – with AUTHORIZATION

MEDICAID – RENAL FAILURE ONLY – VASCULAR CASE BY CASE

NHP(UHC) – with AUTHORIZATIONS (OPEN ACCESS NOT NEEDED)

PREFERRED CARE PARTNERS – MCD PRODUCT IS CARE FL DOES NEED REFERRAL

UNITED HEALTHCARE

UNITED HEALTHCARE –AARP- MCR COMPLETE – DOES NEED AUTHORIZATION

WORKER'S COMP – HEK ONLY AND WITH APPROVAL – REQ SUMMARY OF CASE – APPT MADE ONLY WITH ADJUSTER AND WITH AUTHORIZATION

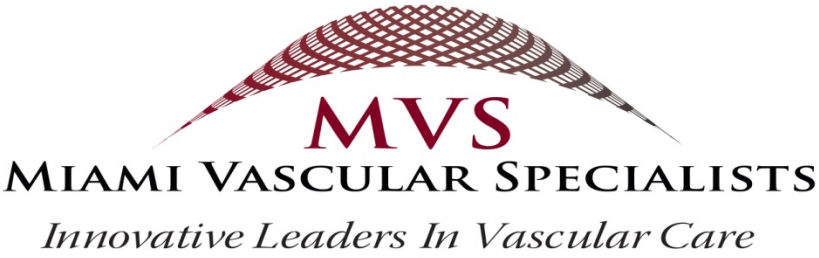
******IF INS CARD STATES OPEN ACCESS DOES NOT REQ REFERRAL*******

MVS
MIAMI VASCULAR SPECIALISTS
Innovative Leaders In Vascular Care

SAMPLE INSURANCE PLAN LIST
Please call the office to verify your plan
305-274-2030
December 2015

Note: Bullets represent plans accepted at this time

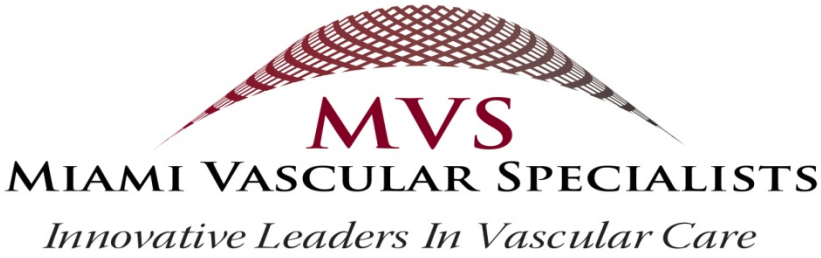
- AARP (United Healthcare)
- AETNA HLTH PLANS AMERICA PPO/EPO
- AETNA CHOICE POS
- AETNA HMO
- AETNA PPO
- AETNA POS
- AETNA OPEN CHOICE PPO
  AETNA SELECT QPOS
- AMERICAN HERITAGE LIFE PPO
  AMERICAN MEDICAL HEALTH HMO
  AMERICAN MEDICAL SECURITY EPO/PPO
  AMERIGROUP FLORIDA MEDICAID
- ASSURANT HEALTH
  AVMED CLASSIC PLUS PPO
- AVMED HEALTH PLAN HMO
- AVMED HEALTHPLAH POS
- AVMED MEDICARE CHOICE HMO
- AVMED OPEN ACCESS HMO
  AVMED SELECT PLUS PPO
- BEECH STREET PPO
- BLUE CARE HMO
  BLUE CROSS HEALTHY KIDS
- BLUE CROSS PPC/PPO
  BLUE CROSS TRADITIONAL
  BLUE CROSS MIAMI DADE BLUE
- BLUE MEDICARE HMO
- BLUE OPTIONS PPO
- BLUE SELECT PPO
- CARNIVAL CRUISE LINES
  CAPP CARE PPO
- CIGNA HMO



- CIGNA POS
- CIGNA HEALTH CARE PPO
- CIGNA LOCAL PLUS PPO

  CORVEL PREFERRED CARE PPO
  COVENTRY CARE LINK HMO
  COVENTRY HEALTHCARE HMO
  COVENTRY HEALTH PLAN HMO
  COVENTRY HEALTH PLAN PPO
  COVENTRY HEALTH CARE PPO/POS
  COVENTRY HEALTH MEDICARE HMO
  COVENTRY HEALTH CARE MEDICAID
- DIMENSION HEALTH PPO
- DIMENSION PPO
  DIMENSION PLUS PPO

- FIRST HEALTH PPO
- FLORIDA BLUE PPO
- FLORIDA BLUE HEALTH OPTIONS HMO
- FLORIDA HEALTH CHOICE PPO
  FLORIDA HEALTHY KIDS
- GREAT WEST HEALTH PLAN PPO
- HUMANA HMO
- HUMANA CHOICE HMO
- HUMANA GOLD PLUS HMO
- HUMANA GOLD PLUS MEDICARE
- HUMANA MEDICAID HMO
- HUMANA PPO/EPO/POS
  JOHN ALDEN PPO
  JMH HMO
  JMH POS
  MEDICA COVER FLORIDA
  MEDICA HEALTHCARE HMO
  MEDICAL MEDICAID
- MEDICA MEDICARE
  MOLINA HEALTHCARE FL
  MOLINA HEALTHCARE FL MEDICAID
  MULTIPLAN PPO
- NHP HMO
- NHP PPO



PPO NEXT
PREFERRED HEALTHCARE NETWORK PPO
PREFERRED MEDICAL PLAN PPO
PREFERRED MEDICAL PLAN HMO

PREFERRED MEDICAL PLAN MEDICAID
PREFERRED MEDICAL PLAN MEDICARE
PRIVATE HEALTHCARE SYSTEMS PPO
PRO AMERICA PPO
SIMPLY HEALTHCARE MEDICAID
SOUTH CARE HEALTHCARE
STAY WELL MEDICAID
SUN HEALTH PPO
SUNCARE HEALTHCARE PPO
SUNSHINE STATE HEALTH PLAN MEDICAID
UNITED BEHAVIORAL HEALTH HMO
UNITED COVER FLORIDA

- UNITED HEALTH HMO
- UNITED HEALTH POS/CHOICE PLUS
- UNITED HEALTH OPEN ACCESS HMO

UNITED HEALTHCARE PPO
UNITED HEALTHY KIDS

- UNITED HEALTHCARE MEDICARE

UNITED HEALTHCARE FLORIDA MEDICAID
UNIVERSITY BEHAVIORAL HEALTH HMO
TRICARE PRIME HMO
TRICARE EXTRA
TRICARE STANDARD
VISTA HMO
VISTA MEDICAID
VISTA MEDICAID HMO
VISTA MEDICARE
VISTA PLATINUM – H1013 - H1076
VITAS HOSPICE
VOCATIONAL REHAB
UNIVERSAL HEALTH SERVICES

MIAMI VASCULAR SPECIALISTS

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