1. Vascular Center of Mobile

2. Glenn Esses, M.D., F.A.C.S

3. Date: ______________________

Name: First________________________ M _________________Last ____________________________

Date of Birth: ____/____/_______ Age: ________ Sex: M F SS#_______________________________

Mailing Address: ______________________________City _________________ ST _____ Zip________

Home Ph.: ___________________ ❒ Cell Ph.: _____________________ ❒ Check Primary Number (√)

Email Address: ____

Referring Doctor: ___________________________________ Phone #: __________________________

Primary Care Doctor: ________________________________ Phone #: __________________________

Insurance # 1: _____________________________ Insurance # 2: ______________________________

Policy Holder's Name: ________________________________ Policy Holder DOB: _________________

Marital Status: S M W D Spouse's Name: ______________________ Phone #: __________________

Reason you came to the Vascular Center: Follow up care? ❒ Yes ❒ No

Other: ____

____

Emergency Contact:

Name: ________________________ Relationship: __________________ Phone #: ________________

Name: ________________________ Relationship: __________________ Phone #: ________________

Why did you choose the Vascular Center? Please indicate all that apply:

❒ Doctor Referral Doctor's Name: __________________ Phone #: ____________________

❒ Friend Referral Name: ____

❒ Website

❒ Radio ad

❒ TV ad

❒ Other: ____

Personal History:

Do you consume alcohol? ❐ Yes ❐ No How often? ___________________
Have you ever smoked? ❐ Yes ❐ No Do you smoke now? ❐ Yes ❐ No
How long have you smoked? ____
How many packs per day do you / did you smoke? ______________________________
When did you stop smoking? ____

List all surgeries (including dates) you have had in the past: ____________________________________

____

____

Do you have, or have you had, any problems with any of the following? Please check the box if yes.

❐ Stroke	❐ Bleeding disorders or Anemia
❐ Dizziness / Blackouts / Seizures	❐ Asthma
❐ Vision loss	❐ COPD
❐ Leg Pain	❐ Back pain
❐ Leg swelling	❐ Bone or Joint problems
❐ Difficulty walking	❐ Gallbladder / Colon / Stomach
❐ High blood pressure	❐ Prostate problems
❐ Diabetes	❐ Gynecological problems
❐ Blood clots / DVTs	❐ HIV/AIDS
❐ Aneurysms	❐ Hepatitis
❐ Heart Disease	❐ Covid-19
❐ Shortness of breath	❐ Cancer - Type: _____________________________

❐ Please list any additional medical conditions you have that were not listed above:

____

____

____

Family History:

Has anyone in your family ever had any of the following? (Please check the appropriate box):

Father:	***Mother:***	***Brother/Sister:***
❐ Cancer ❐ Heart problems	❐ Cancer ❐ Heart problems	❐ Cancer ❐ Heart problems
❐ High blood pressure	❐ High blood pressure	❐ High blood pressure
❐ Aneurysm ❐ Diabetes	❐ Aneurysm ❐ Diabetes	❐ Aneurysm ❐ Diabetes
❐ Varicose veins ❐ Stroke	❐ Varicose veins ❐ Stroke	❐ Varicose veins ❐ Stroke

Medication Information

Pharmacy Name: ___________________________________ Phone #: ______________________________

Address: _____________________________ City: _______________________ State: ______ Zip: _______

Drug allergies: ____

Describe your reaction: ____

____

(If you brought your own medication list, let us make a copy)

Medication Name:	Milligrams	How often do you take it?

Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient: ____ Date of Birth: ____________________

Address: ____ SSN: ___________________________

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Information to be used or disclosed must be identified in a specific and meaningful fashion and must reveal the purpose of the use and disclosure. Please check all that apply:

❒ Medical Information

❒ Financial Information (Medical History)

❒ Demographic Information

❒ Insurance Information

List individuals to whom information can be released (other than those required by law):

Please identify by name:

____ ____

____ ____

Expiration Date: ❒ Indefinitely (no expiration)

❒ Other (please specify): ___________________________

____ ________________________________

Patient\Responsible party Date

Cancellation and No-Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide us at least a 24 hour notice.

Patients who do not arrive for their appointment at their scheduled time without notifying our office will be considered a **NO-SHOW**. A patient who has had 2 or more missed appointments in a 12 month period may be dismissed from the practice and thus will be denied any future appointments.

Patients may also be subject to the following fees:

$25.00 fee for a missed office appointment
$50.00 fee for a missed ultrasound appointment
$300.00 fee for a missed procedure appointment

The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that special circumstances may cause you to cancel your appointment within 24 hours. Fees in this instance may be waived, but only with management approval.

Privacy Agreement

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

____ ______________
Signature of Patient / Responsible Party Date

____
Printed Name

Patient Responsibilities

To treat you at the highest professional level, we require the following from our patients:

1. Notify us of any changes in your address, contact numbers or insurance information at the time of change.

2. Be familiar with your insurance requirements regarding necessary referrals or prior authorizations. If you need a referral, please notify us or your primary care physician before your office visit.

3. Provide us with copies of any testing done at another office or hospital.

4. Co-payments must be made at the time service is rendered. (Your insurance requires this.) There could be separate co-payments for an office visit and vascular laboratory testing.

5. The fee for a returned check is $30.00.

6. The fee for completing any disability, life insurance or health policy form is $12.00. Payment is due when the form is given to us to complete. Please allow our office 14 days to complete the forms.

Assignment, Acknowledgement and Guarantee of Payment

I authorize the release of my medical information to any pertinent party, including that necessary for peer review, in addition to any insurance companies for the processing of my claims. I authorize, by signing below, payment of medical benefits directly to Vascular Center of Mobile. I understand I am financially responsible for any deductibles, non-covered services, and balances not covered by any insurance carrier. I understand and accept the fee charged as legal and lawful and agree to pay said fees, including all collection agency fees (33.33%), attorney fees and/or court costs, if such becomes necessary.

____ ________________

Patient / Responsible Party Signature Date

____

Printed Name