Vascular and Vein

NEW PATIENT INTAKE FORM

First Name: _____ M.I._____ Sex: ☐ Male ☐ Female ☐ Other

Last Name: _____

Date of Birth: _____SSN: _____-_____-_____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone: _____ Email:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ Other ☐ Declined to Specify

Language: ☐ English ☐ Spanish ☐ Other: _____

Are you currently in a Skilled Nursing/Rehab facility? ☐ Yes ☐ No

If yes, Skilled Nursing/Rehab facility name: _____

Name of Primary Care Physician: _____

INSURANCE INFORMATION

Policy Holder's Full Name: _____ Date of Birth: _____

Policy Holder's SSN: _____-_____-_____ **This is requested for insurance verification to prevent delays in billing.*

Patient Name: _____ DOB: _____

SOCIAL HISTORY

Occupation/Job Title: _____

Tobacco Use: ☐ Never Smoked ☐ Occasional Smoker ☐ Exposed to Passive Smoke
☐ Former Smoker ☐ Daily Smoker ☐ Other Form of Tobacco
Date stopped: _____

Alcohol Use: ☐ Does Not Drink Alcohol ☐ Occasional Drinker ☐ Occasional Heavy Use
☐ 1-2 Drinks Daily ☐ 3-5 Drinks Daily ☐ Daily Heavy Use

Drug Use: Are you taking any unprescribed drugs, including recreational drugs?
☐ Yes If yes, name of drug_____
☐ No

Exercise: ☐ Exercises Regularly ☐ Exercises Occasionally ☐ Does Not Exercise

HISTORY OF PRESENT ILLNESS / REASON FOR VISIT

Reason for today's visit: _____

Have you had any of the following testing within the 12 months that pertains to your visit today?

☐ US ☐ MRI ☐ CT ☐ EMG ☐ Bone Density (DEXA) ☐ Other: _____
Where were these tests completed? _____

FAMILY MEDICAL HISTORY

	Father	Mother
Blood clots (DTV)	☐	☐
Cancer	☐	☐
Clotting disorder	☐	☐
Heart attack	☐	☐
High blood pressure	☐	☐
Pulmonary embolism	☐	☐
Stroke/TIA	☐	☐

Patient Name: _____ DOB: _____

SURGICAL HISTORY

Select all that apply:	Year of Surgery:
☐ Pacemaker/Defibrillator	
☐ Aneurysm	
☐ Bypass/Graft	
☐ Carotid - Left	
☐ Carotid – Right	
☐ Dialysis Fistula/Graft	
☐ Abdominal Surgery	
☐ Hernia	
☐ Cancer Surgery	
☐ Other:	
☐ No Surgical History	

Personal Medical History

Please select all that apply:					
☐	Alzheimer's	☐	Anxiety	☐	Autoimmune Condition
☐	Asthma	☐	Blood Clot (DVT)	☐	Cancer
☐	Clotting disorder	☐	COPD	☐	Depression
☐	Diabetes Type 1	☐	Diabetes Type 2	☐	Esophageal reflux
☐	Gout	☐	HIV	☐	Heart disease
☐	Heart attack	☐	Hepatitis	☐	High blood pressure
☐	High cholesterol	☐	History of fractures	☐	Kidney disease
☐	Liver disease	☐	Migraines/Headaches	☐	MRSA Infection
☐	Osteoarthritis	☐	Peripheral neuropathy	☐	Pulmonary embolism
☐	Rheumatoid arthritis	☐	Seizures	☐	Sleep apnea
☐	Stomach ulcers	☐	Stroke/TIA	☐	Thyroid disease
☐	Osteoporosis	☐	Vertigo	☐	Lupus
☐	Parkinson's	☐	Multiple Sclerosis (MS)	☐	Other: _____

Patient Name: _____ DOB: _____

VITALS

Height: _____ feet _____ inches Weight: _____ pounds

ALLERGIES

Are you allergic to any of the following? ☐ Latex ☐ Metal ☐ Contrast dye ☐ Iodine

Medication allergies AND reaction: _____

MEDICATIONS

Preferred Pharmacy Name: _____ Location of Pharmacy: _____

Are you currently taking any medications? (Prescription, over-the-counter, vitamins, or supplements) ☐ Yes ☐ No

If yes, please list all current medications below or provide a list at your appointment:

Medication Name	Dose/Strength/Frequency

PATIENT AUTHORIZATION

All the information provided is complete and accurate to the best of my knowledge. I authorize Advanced Orthopedics & Sports Medicine d/b/a Sano Orthopedics to release my personal, confidential health and billing information to my emergency contact, guarantor, referring provider, primary care physician, pharmacy, health insurance(s), workers' compensation carrier / agent and attorney. I understand that my photo identification, insurance card(s) and any applicable copayment or general deductible payment are required at the time of the visit.

If insured by Medicare, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself for to party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible in part for my treatment.

Notice of Privacy, Release of Information & Sano Policy Agreement: Sano Orthopedics will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed Privacy Policy to help you better understand our policies regarding your personal health information. The Privacy Policy, Controlled Substance Policy, Financial Policy, and Late & No Show Policy are available our https://www.sanoorthopedics.com/patient-forms/ and copies are available for distribution, if requested.

I certify that I have read and understand the foregoing, is the patient or one authorized by the patient to execute the above and accepts the terms thereof.

Authorization for Medical Treatment: This consent form is an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). By signing below, I (or my authorized representative) authorize Sano to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to assess and maintain my health effectively. I understand that it is the responsibility of my individual healthcare providers to explain the reasons for any treatment, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options. I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment. Authorization is hereby granted for treatment.

Insurance Assignment and Financial Acknowledgement: I hereby authorize Sano Orthopedics to furnish information to insurance carriers concerning my care and treatment and assign to the provider all payments for medical services rendered. I understand I am financially responsible for all charges whether or not covered by my insurance. I understand I am also responsible for providing up-to-date and accurate insurance information. I certify I will pay to Sano any co-payments, co-insurance, deductibles or cost of non-covered products or services. I will promptly pay Sano any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by insurance if I fail to provide appropriate insurance information for billing.

Print Patient Name: _____ Date of Birth: _____

Patient or Guardian Signature: _____Today's Date: _____

Print Guardian Name: _____ Relationship to Patient: _____

CONSENT TO TRANSCRIPTION SERVICE

In our commitment to prioritizing your care, we have partnered with various healthcare technologies and services to enhance the focus on you during your visit. These technologies assist in documenting your appointment and generating summaries, aiding our healthcare professionals in focusing solely on your needs. These tools may include AI-related solutions, comprehensive visit recordings, and organization of notes. These tools and services are vital in improving the accuracy, efficiency, and compliance of medical appointments and healthcare operations.

We take your privacy and data security seriously, adhering to stringent privacy regulations and implementing safeguards. Recorded segments without identifiable information may be used for training, quality assessment, and analysis. Some de-identified information and data required for essential healthcare functions may be retained. Recognizable portions of the recordings will be used for treatment, payment, and healthcare operations.

We appreciate your understanding and support as recording your visit helps us provide better care to you. Please share this information with any visitors accompanying you, as you are responsible for notifying them. If at any point you or any visitors with you wish for the provider not to use transcription services, notify our team, so we can remove and/or turn it off immediately.

By signing below, you and any accompanying visitors give explicit consent for this clinical practice and the associated healthcare technologies to record, transcribe, and document your appointments.

Print Patient Name: _____ Date of Birth: _____

Patient or Guardian Signature: _____Today's Date: _____

Print Guardian Name: _____ Relationship to Patient: _____

PHI RELEASE FORM

We understand that communicating with you about your healthcare is important. Thus, you need to authorize us to communicate with designated individuals regarding your healthcare. This includes complete health records including, but not limited to, diagnoses, lab results, other test results, imaging, treatment, and billing records for all conditions. I give consent for sharing protected health information (PHI) to:

- ☐ Please do not discuss my medical information with anyone other than myself. I understand that checking this does not prevent Sano from disclosing my medical or billing information as may be otherwise allowed under state and federal privacy laws.

- ☐ I authorize Sano to share my protected health information with designated individuals.

Contact Name: _____ Relation: _____

Contact Phone: _____

Contact Name: _____ Relation: _____

Contact Phone: _____

Consent for sharing protected health information with individuals listed. Select all that apply.

- ☐ I authorize communication over the phone.
- ☐ I authorize communication via secure text.
- ☐ I authorize in-person communication.
- ☐ I authorize individuals to pick up information on my behalf.
- ☐ I authorize detailed messages to be left on voicemail.

*Disclaimer: This authorization form expires one year from the signed date. I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing.

Patient or Guardian Signature: _____Today's Date: _____

Printed Name and Relationship to Patient: _____