

Name _____ Age _____ Gender Male Female Transgender

Referring Physician _____ PCP (if different) Jordan Glenn

Chief Complaint _____ When did it start? _____

How did you hear about us _____

Medications you are currently taking: None Do you take aspirin? 81mg _____ 325mg _____

Have you ever been treated for: sleep apnea If yes...Do you use a CPAP No _____ Yes _____ Other _____
 heart disease congestive heart failure hypothyroid asthma high blood pressure
 diabetes type 1 high cholesterol COPD heart attack diabetes type 2 CVA/strokes

Other Medical Problems none _____

Allergies to Medications: (include reactions) No known allergies to medications
Medication _____ Reaction _____ Medication _____ Reaction _____
Medication _____ Reaction _____ Medication _____ Reaction _____

GYN History
Last menstrual period _____ # pregnancies _____ # births _____ # miscarriages/abortions _____ # c-sections _____

Are you pregnant? No _____ Yes _____ Maybe _____

Prior Surgeries (include dates) none _____

Family History-has any blood relative ever had: (list which family member) (circle sibling)
Heart Disease High Blood Pressure diabetes cancer emphysema birth defects anesthesia problem
 mother mother mother mother mother mother mother
 father father father father father father father
 brother/sister brother/sister brother/sister brother/sister brother/sister brother/sister brother/sister
Any family history of bleeding problems? No _____ Yes _____ Other _____

Social History
Have you ever smoked? No _____ Yes _____ : If yes: #packs per day _____ for _____ #years. If you quit, when?: _____ (date)
Currently drink alcohol? No _____ Yes _____ If yes: # drinks/day: _____ for _____ #years If you quit, when? _____ (date)
Occupation _____

Review of Systems (Are you experiencing any of the following?)
Yes No Yes No
____ Fever / chills / night sweats (circle) _____ Decreased sensation
____ Daytime drowsiness/Somnolence _____ Bruising
____ Exercise regularly _____ Rash / skin lesions
____ Weight loss _____ Swollen lymph nodes, if yes where _____
____ Vision disturbances _____ Abdominal Pain
____ Hearing difficulties _____ Diarrhea / constipation (circle)
____ Cough _____ Nausea / vomiting (circle)
____ Difficulty climbing a flight of stairs _____ Rectal bleeding
____ Snoring / nighttime breathing difficulty (circle) _____ Joint pain
____ Chest pain _____ Muscle weakness / sensation loss
____ Irregular heart beat _____ Bleeding problems
____ Shortness of breath _____ Blood clots / embolism / DVT / varicose veins (circle)
____ Painful or abnormal urination _____ History of anesthesia problems

Screening Height _____ (inches) Weight _____ (lbs) ---- patient reported -must be completed

PATIENT INFORMATION

LAST NAME		FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #	
HOME ADDRESS				CITY	STATE	ZIP	SEX
HOME PHONE #	EMAIL		CELL PHONE #		MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> OTHER		
REFERRING PHYSICIAN NAME AND PHONE NUMBER					PCP NAME & PHONE#		
HOW DID YOU HEAR ABOUT US: <input type="checkbox"/> PROVIDER REFERRAL <input type="checkbox"/> INTERNET <input type="checkbox"/> WORD OF MOUTH <input type="checkbox"/> PREVIOUS PATIENT <input type="checkbox"/> CURRENT PATIENT <input type="checkbox"/> BROCHURE <input type="checkbox"/> INSURANCE <input type="checkbox"/> HOSPITAL <input type="checkbox"/> MAILER/MAGAZINE/NEWSPAPER <input type="checkbox"/> OTHER _____							

MANDATORY-PER NEW CMS GUIDELINES

LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> RUSSIAN <input type="checkbox"/> CREOLE <input type="checkbox"/> OTHER _____	ETHNICITY <input type="checkbox"/> LATINO/HISPANIC <input type="checkbox"/> NON LATINO / HISPANIC	RACE <input type="checkbox"/> ASIAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> REFUSE TO REPORT
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RESPONSIBLE PARTY INFORMATION (financial responsibility)

LAST NAME				FIRST NAME	MI	HOME PHONE	
ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #			
EMPLOYER		OCCUPATION			WORK PHONE		
EMPLOYER ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			

EMERGENCY INFORMATION

NEXT-OF-KIN OR CONTACT INFO -	PHONE
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PHARMACY

NAME AND LOCATION	PHONE
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INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION

PRIMARY INSURANCE	SUBSCRIBER NUMBER / GROUP NUMBER	DATE OF BIRTH OF PRIMARY
SECONDARY INSURANCE	SUBSCRIBER NUMBER	DATE OF BIRTH

ASSIGNMENT OF BENEFITS, FINANCIAL POLICY TERMS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I have read, agree to and signed the Jordan J Glenn PLLC Financial Policy.

I agree I will be responsible for any unpaid balances for any reason.

I hereby authorize direct payment to Jordan J Glenn PLLC of any medical benefits payable to me for the services provided at Jordan J Glenn PLLC.

X

Patient Signature or Signature of Guardian or Parent

Date

RECORDS RELEASE

I hereby authorize Jordan J Glenn PLLC to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X

Signature or Signature of Guardian or Parent

Date

JG

Jordan J Glenn PLLC

Patient Name:

Date of Birth:

I acknowledge that I have been provided the Jordan J Glenn PLLC Notice of Privacy Practices:

- It tells me how the organization will use my health information for the purpose of my treatment, payment for my treatment and its health care operations
- The notice explains in more detail how the practice may use and share my health information for purposes other than treatment, payment and health care operations.
- The organization will also use and share my health information as required/permitted by law.

Printed Patient Name

Patient's Date of Birth

Signature of Patient

Date

Signature of Client / Personal Representative

Relationship to Patient

I consent to receive calls from Jordan J Glenn PLLC, providers/staff for my protected healthcare and other services at the phone numbers provided by myself, including my wireless number I provided, I understand that I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Please list all family member(s)/guardian(s) that may access your medical records and/or financial and billing information. Please list all:

1. _____ Relationship _____ Phone # _____
Medical Only Billing Only Both
2. _____ Relationship _____ Phone# _____
Medical Only Billing Only Both
3. _____ Relationship _____ Phone# _____
Medical Only Billing Only Both
4. _____ DO NOT speak to any family members
(initial)

I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or my legal representative, and delivered to Jordan J Glenn PLLC, Attn: HIPAA Compliance Officer, via mail or in person. It will be effective only when Jordan J Glenn PLLC actually received it. The information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations. To access our complete Notice of Privacy Practices, please call the office to have a copy sent to you.



Jordan J Glenn PLLC

Financial Policy Acknowledgment:

Patient Name: _____ **DOB** _____

Please initial below to acknowledge that you have received a copy of Thunderbird Vein HIPAA policy.

Initial: _____

Please initial below to acknowledge that you have read our financial policy, which reflects that you as the patient are ultimately responsible for the charges associated with your care.

Initial: _____

Please initial below to acknowledge that you are aware of our appointment cancellation/no-show policy which states:

If **48-hour** notice is not given prior to an **office appointment**, you will be charged a \$25 fee.

Initial: _____

If **72-hour** notice is not given prior to a **scheduled surgery**, you will be charged a \$250 fee.

Initial: _____

To access our financial policy, please visit our website at www.aasaz.com Or call the office to have a copy sent to you.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____