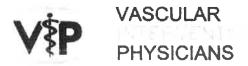


NEW PATIENT INTAKE FORM

NAME-LAST FIRST		M.I.	DATE OF BIRTH		AGE	SEX [] M [] F	SOCIAL SECURITY NO.		
DATE OF YOUR APPOINTMENT					WOULD YOU	OULD YOU LIKE TO BE CONTACTED BY EMAIL? 'ES [] NO			
HOME ADDRESS	СІТУ			ATE	ZIP CODE		[] SINGLE []	MARITAL STATUS [] SINGLE [] MARRIED [] DIVORCED [] WIDOWED	
PREFERRED PHONE NUMBER TO BE CONTACTED						PREFERRED NUMBER [] HOME [] CELL			
IN CASE OF EMERGENCY CONTACT NAME EMERGENCY CONTACT PHONE						RELATIONS	RELATIONSHIP		
PRIMARY CARE PHYSICIAN	MARY CARE PHYSICIAN PRIMARY PHONE NUMBER					DATE OF LAST VISIT			
PREFERRED PHARMACY PHONE NUMBER									
WHO SHOULD WE THANK FOR YOUR REFFERAL REFER						REFERE	RRING PHONE NUMBER (IF APPLICABLE)		
INSURANCE COMPANY					EMPLO	EMPLOYER OF INSURED			
ID OR POLICY NUMBER POLI						POLICY	ICY HOLDER OR INSURED NAME / DOB		
GROUP NUMBER					PRE-CE	PRE-CERTIFICATION PHONE NUMBER			
SYMPTOMS OR REASON FOR VISIT		CURRENT SEV	ERIT	Y OF PRO	BLEM		PREVIO	OUS TREATMENTS FOR	
1)							(MED	PROBLEM S OR SURGERY, ETC.)	
	PLEASE RATE YOUR CONDITION ON A SCALE OF 1 WITH 1 BEING NORMAL LIFESTYLE				OF 1-10				
2)	AND 10 BEING SEVERE EFFECTS ON LIFESTYLE								
3)	1 2 3 4 5 6 7 8 9 10								
	WHEN DID YOU FIRST NOTICE THE PROBLEM?					HOW OF	PROBLEMS?		
4)	FAMILY HISTORY OF SIMILAR PROBLEMS								
[] YES [] NO									
WHAT IS THE MEDICAL PROBLEM YOU NEED ADDRESSED TODAY?									
DOES ANYTHING MAKE YOUR PROBLEM WORSE OR BETTER?									
HAVE YOU BEEN EVALUATED FOR THIS PROBLEM BEFORE (WHAT WAS THE DIAGNOSIS GIVEN?)									

NAME-LAST	FIRST	M.I.		APPOINTMENT DATE
PLEASE LIST ALLERGIES (MEDICATION	NS OR FOODS)		TYPE OF REACTION (RASH, DIFFICULTY BREA	THING, ETC.)
•	,		` ′	
PLEASE LIST ALL MEDICATIONS (INCLUDING OVER THE COUNTER, VI	TAMING AND HERBAIG		STRENGTH AND FREQUENCY	
(INCLODING OVER THE COOKTER, VI	TAMINS AND HERBALS)			
PLEASE LIST ALL IMPLANTS (PENILE,	BREAST, PACER, ETC.)			
				

6286 Briarcrest Ave., Suite 300 Memphis, TN 38120 FAX 901.531.7199



901.747.1007

A Decision of Abil South languages the laps are set Y

www.vipphysiciansmemphis.com

Authorization to Release/Obtain Medical Records

I hereby authorize the disclosure of information from the health records of:

	t's First Name	Patient's Last Name
Phone	number DO	B:
Health	n information to disclose:	
0	All information	
0	Progress notes	
С	Treatment Summary	
0	Labs	
0	Imaging studies	
0	Other(specify)	
Metho	od of Disclosure:	
0	A al al a a a a C	
0	Release medical records to Vascular Int	erventional Physicians from:
	Name:	
	Address or Fax No:	
	Expiration : Unless otherwise revoked by	you, this authorization shall remain in effect until such time
	Expiration: Unless otherwise revoked by your relationship as a patient of Vascular In	
Signatu	your relationship as a patient of Vascular In	eterventional Physicians is officially ended.
Signatu		iterventional Physicians is officially ended.

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VASCULAR **PHYSICIANS**

7601 Southerest Parkway Southaven, MS 38671 FAX 901.531.7199

901.747.1007

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www.vipphysiciansmemphis.com

To our patients: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

Vascular Interventional Physicians **Notice of Privacy Practices** (Summary Notice-Patient Copy)

PLEASE REVIEW THIS PAGE, SIGN BELOW, AND RETURN THIS COVER PAGE TO THE STAFF PERSON WHO GAVE IT TO YOU.

Under This Top Page, You Should Have Received A Longer Notice Document. If You Did Not, Please Request One From Our Staff Person Who Provided This Page To You.

Please keep longer Notice document and take it home with you. YOU MAY REVIEW THE LONG-FORM NOTICE EITHER NOW OR LATER In either case, let us know if you have any questions after reviewing it.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION:

Each time you visit a health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. The doctors and staff of our practice use and maintain this health information relating to the care you receive from us.

The longer Notice attached to this page contains information to help you understand what is in your medical record and how your health information is used. This helps you ensure the accuracy of such information, and helps you better understand who, what,

when, where and why others may have access to yo	our health information.
Patient name (please print)	Signature or initials of patient or
	personal representative*
	*If personal representative, please list relationship
(For office use only)	
VIP staff person's name:	
Dating to	e
□ (Check if applicable) Patient did not acknowledge	



Friends and Family Designation Form

First a	nd Last	name of Patient:		
Patien	t Date o	of Birth		
1.1.	VIE J,	that Vascular Interventional Physicians may disclose information about my care d(s) whom I designate below:	, a division of Mid-South Imagin or payment for my care to family	ng & Therapeutics, member(s) or close
1.	Name	2:	Relationship:	
2.	Name	y	Relationship:	
3.	Name	::	Relationship:	
care.	In the a	that VIP is subject to the federal HIPAA we the information that is relevant to the event of an emergency or if I am incap termine whether a disclosure is in my le e person's involvement with my care or	acitated, VIP may, in the exercise pest interests and if so, disclose interests and if so, disclose in the exercise pest interests and if so, disclose in the exercise and if so, disclose in the exercise pest interests and if so, disclose in the exercise and if so, disclose in the exercise and its period of the exercise and	or payment for my of its professional
such re	OKC IIII	that designating family and friends on the designation, in writing, at any time, to be is not effective to the extent that VIP action.	v contacting lenter contact info	I understand that
This coreceiv	lesignat ing serv	tion will be effective from the date si vices from VIP (unless sooner revoked	gned below until the date on whoy me in writing, as described abo	nich I am no longer ove).
Signat	ture:		Date:	
Print n	name of	patient or personal representative, if a	oplicable:	
Relatio	onship	to patient;		
27046	305.1			