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

VASCULAR INTERVENTIONAL PHYSICIANS

55 Physicians Lane
Southaven, MS 38671
FAX 901.531.7199

901.747.1007

A Division of Mid-South Imaging & Therapeutics, P.A.

www.vipphysiciansmemphis.com

New Patient Intake Form

NAME - LAST FIRST M. I	DATE OF BIRTH	AGE	SEX { }MALE { }FEMALE	SOCIAL SECURITY NO.

DATE OF APPOINTMENT	EMAIL ADDRESS	WOULD YOU LIKE TO BE CONTACTED BY EMAIL? { }YES { }NO

HOME ADDRESS	CITY	STATE	ZIP CODE	MARITAL STATUS { }SINGLE { }MARRIED { }DIVORCED { }WIDOWED

PREFERRED PHONE NUMBER TO BE CONTACTED	PREFERRED NUMBER { }HOME { }CELL

IN CASE OF AN EMERGENCY CONTACT NAME	EMERGENCY CONTACT NUMBER	RELATIONSHIP

PREFERRED PHARMACY (LOCAL)	PHARMACY NUMBER

PRIMARY CARE PHYSICIAN	PRIMARY PHONE NUMBER

PRIMARY INSURANCE/ID NUMBER	SECONDARY INSURANCE/ID NUMBER

COMMENTS:

NAME-LAST	FIRST	M.I.	APPOINTMENT DATE

PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPERIEINCED IN THE PAST 6 MONTHS

GENERAL	EASILY FATIGUED	FATIGUED ONLY AFTER EXERCISE	FATIGUED UPON WAKING	EXCESSIVE WEIGHT GAIN	EXCESSIVE WEIGHT LOSS	NIGHT SWEATS	FEVER
BLOOD	ANEMIA (LOW BLOOD COUNT	BLEEDING DISORDERS	TAKING COUMADIN	EASY CLOTTING	BLOOD CLOT	DVT	
SKIN	BLEEDING	EASILY BRUISING	SORES	ITCHING	SCALING	VARICOSE VEINS	NONHEALING LEG / FOOT WOUNDS
GLANDS	ENLARGEMENT	PAIN	DRAINAGE	LYMPHOMA			
EYES	GLASSES	CATARACTS	TRAUMA	INFECTION	TEMPORARY BLINDNESS	VISUAL LOSS	GLAUCOMA
EAR	INFECTION	LOSS OF HEARING	PAIN	RINGING IN THE EARS	RUPTURED EAR DRUM		
NOSE	SINUS INFECTION	NOSE BLEEDS	RUNNY NOSE				
MOUTH/THROAT	DIFFICULTY CHEWING	EXCESSIVE TONGUE MOVEMENT	PAIN	DENTURES	FREQUENT SORE THROAT	HOARSENESS	PAIN OR DIFFICULTY SWALLOWING
NECK	LIMITATION OF MOVEMENT	PAIN	STIFFNESS	TRAUMA	WEAKNESS	SWELLING	
RESPIRATORY	ASTHMA	COUGHING	LUNG INFECTIONS	COUGHING UP MUCUS	COUGHING UP BLOOD	SHORTNESS OF BREATH AT REST	SHORTNESS OF BREATH AFTER EXERTION
HEART / CV	IRREGULAR HEARTBEAT	CHEST PAIN	COLD HAND AND / OR FEET	PAIN IN LEGS AFTER WALKING	PALPITATIONS	SHORTNESS OF BREATH	SWELLING OF HANDS AND/OR FEET
GI	NAUSEA	INDIGESTION	VOMITING	ABDOMEN PAIN	VOMITING BLOOD	JAUNDICE (YELLOW SKIN)	BLOOD IN STOOL
GENITOURINARY	CHANGE IN COLOR OF URINE	DECREASED URINATION	PAINFUL URINATION	FREQUENT URINATION AT NIGHT	INCREASED URINATION	CHANGE IN MENSTRUAL CYCLE	ERECTILE DYSFUNCTION IMPOTENCE
SKELETAL	GENERALIZED WEAKNESS OF MUSCLES	MUSCLE PARALYSIS	DECREASE IN MUSCLE SIZE	DECREASE IN MUSCLE STRENGTH	INVOLUNTARY MOVEMENT	ARTHRITIS	JOINT PAIN
NEUROLOGICAL	DIZZINESS	FALLS / BALANCE DIFFICULTY	SLURRED SPEECH	SEVERE HEADACHES	SEIZURE	BURNING PAIN/ NUMBNESS/ TINGLING	LOW BACK PAIN
PSYCHIATRIC	MEMORY LOSS	DIFFICULTY FOCUSING	DEPRESSION	MOOD SWINGS	SLEEP DISTURBANCE	BLACK OUTS	LIGHT HEADEDNESS

THE FOLLOWING QUESTIONNAIRE IS INTENDED TO HELP US BETTER EVALUATE AND TREAT YOUR MEDICAL PROBLEMS. WE APPRECIATE YOU FILLING IT OUT IN ITS ENTIRETY. SHOULD YOU HAVE ANY QUESTIONS ABOUT WHAT INFORMATION TO INCLUDE DON'T HESITATE TO ASK THE OFFICE STAFF.

PATIENT SIGNATURE	DATE

NAME -LAST	FIRST	M.I.	APPOINTMENT DATE

PLEASE LIST ALLERGIES (MEDICATIONS OR FOODS)	TYPE OF REACTION (RASH, DIFFICULTY BREATHING, ETC.)

PLEASE LIST ALL MEDICATIONS (INCLUDING OVER THE COUNTER, VITAMINS, AND HERBALS)	STRENGTH AND FREQUENCY

PLEASE LIST ALL IMPLANTS (PENILE, BREAST, PACER, ETC.)

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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 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 a 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 your 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: _____

Patient record #_____ Date_____

- (Check if applicable) Patient did not acknowledge receipt of Notice (explain): _____

VASCULAR
INTERVENTIONAL
PHYSICIANS

Friends and amid Designation form

First and Last name of patient: _____
Patient Date of Birth: _____

I understand that Vascular Interventional Physicians, a division of Mid-South Imaging & Therapeutics, P.A. ("VIP"), may disclose information about my care or payment for my care to family member(s) or close friend(s) whom I designate below:

1) Name: _____ Relationship: _____

2) Name: _____ Relationship: _____

3) Name: _____ Relationship: _____

I understand that VIP is subject to the federal HIPAA privacy rules and may only disclose to any person I designate above the information that is relevant to that person's involvement in my care or payment for my care. In the event of an emergency I am incapacitated, VIP may, in the exercise of its professional judgement, determine whether a disclosure is ill my best interests and, if so, disclose information directly relevant to the person's involvement with my care or as needed for notification purposes.

I understand that designating family and friends on this form is voluntary. I understand that I have the right to revoke this designation, in writing, at any time, by contacting VIP at 901-747-1007.I understand that such revocation is not effective to the extent that VIP has already relied on this form for the use or disclosure of my information.

This designation will be effective from the date signed below until the date on which I am no longer receiving services from VIP (unless sooner revoked by me in writing, as described above).

Signature: _____ Date: _____

Print name of patient or personal representative, if applicable: _____

Relationship to patient: _____

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Authorization to Release/Obtain Medical Records

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

Patient's First Name_____ Patient's Last Name_____

Phone number_____ DOB _____

Health information to disclose:

- o All information
- o Progress notes
- o Treatment Summary
- o Labs
- o Imaging
- o Other(specify)

_____

Method of Disclosure:

- o Release medical records from Vascular Interventional Physicians to:
  Name: _____
  Address or fax no: _____
- o Release medical records to Vascular Interventional Physicians from:
  Name: _____
  Address or Fax No: _____

Expiration: Unless otherwise revoked by you, this authorization shall remain in effect until such time as your relationship as a patient of Vascular Interventional Physicians is officially ended.

_____ _____

Signature of patient or personal representative . Printed name of patient or personal representative

_____ _____

Relationship to patient (if representative) Date