South Valley Vascular
BASS Medical Group

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384 Pearson Drive, Porterville, CA 93257
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☐ Hanford Office
125 Mall Drive, Suite 211B, Hanford, CA 93230
(559) 825-6204

Patient information

Full name _____ _____ _____
first *middle* *last*

Home address _____ _____ ____ _____
street *city* *state* *ZIP code*

Telephone _____ _____ e-mail address _____
home/mobile *work*

Date of birth ___/___/_____ Age ____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Other
day month year

Ethnicity _____ Language _____

Driver license number _____ Social Security number ___–__–_____
or state ID number

Primary care doctor _____ _____
name *telephone*

Referring doctor _____ _____
name *telephone*

How did you find out about us? _____

Responsible party information

Full name _____ _____ _____
first *middle* *last*

Home address _____ _____ ____ _____
street *city* *state* *ZIP code*

Telephone _____ _____ e-mail address _____
home/mobile *work*

Driver license number _____ Social Security number ___–__–_____ Relationship to patient _____

Employer _____ _____
employer name *telephone*

Primary insurance _____ _____ _____ _____
insurance company name *Member ID* *Group number* *Plan number*

Secondary insurance _____ _____ _____ _____
insurance company name *Member ID* *Group number* *Plan number*

Emergency contact

Name _____ Telephone _____
Name of nearest relative who is not living with you

Reminder about insurance

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician and is not a substitute for payment. Some companies pay a lump sum compensation for certain procedures, and others pay a percentage of the load. It is your responsibility to pay any deductible amounts, coinsurance, or any other balance not paid by insurance.

Assignment of Benefits – Financial Agreement

I directly assign all medical / surgical benefits for South Valley Vascular and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to ensure payment of benefits. I also agree that a photocopy of this agreement will be valid as the original.

Patient signature _____ Date _____

Medical history

Do you have or have you ever had any of the following?

- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Irregular heartbeat
- ☐ Embolism
- ☐ Aneurism
- ☐ Diabetes
- ☐ Pacemaker
- ☐ Heart failure
- ☐ Renal disease
- ☐ Lung disease
- ☐ Compression stockings

Family history of vascular disease

☐ Aneurisms ☐ Varicose veins ☐ Heart disease ☐ Diabetes

Allergies

☐ Latex/talc ☐ Tape ☐ Seafood ☐ Other foods _____

☐ Penicillin ☐ Other medicines _____

How far can you walk comfortably? _____

Please list all your past surgeries. _____

_____

Tell us if you are currently experiencing any of these symptoms.

- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ New eyeglasses
- ☐ Blurry vision
- ☐ Double vision
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Nosebleed
- ☐ Sinusitis
- ☐ Dentures
- ☐ Difficulty swallowing
- ☐ Bleeding gums
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Leg swelling
- ☐ Heart murmur
- ☐ Leg cramps
- ☐ Cough
- ☐ Snoring
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea/constipation
- ☐ Indigestion
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Anemia
- ☐ Bruising
- ☐ Rash
- ☐ Lumps
- ☐ Memory loss
- ☐ Headache
- ☐ Dizziness
- ☐ Fainting
- ☐ Numbness
- ☐ Weakness
- ☐ Clotting problems
- ☐ Thyroid problems
- ☐ Kidney/urinary problems

Occupation _____ **Whom do you live with?** _____

Alcohol consumption ☐ Heavy ☐ Occasional ☐ Never **Tobacco use** ☐ Heavy ☐ Occasional ☐ Never

Please list all medications you currently take. _____

_____

Non-prescription medications _____

Dialysis _____ **Days** _____ **Time** _____ ☐ a.m. ☐ p.m.
facility name

Nephrologist _____
name

What pharmacy do you regularly use? _____
name *location*