VANCOUVER
VEIN & SURGICAL CENTER
CHRISTOPHER RUBANO, MD

Today's Date: _____

Patient's Name: _____ Date of Birth: ____/____/_____ Age: _____

SSN: ____-____-_____ Marital Status: _____ Spouse's Name: _____

Email _____Parent/Guardian Name (if patient is under 18):_____

Address: _____

Phone #: (_____)_____-_____ Cell Phone #: (_____)_____-_____ Is Text Message Allowed: Yes No

Emergency Contact (Name, Relationship, Phone #): _____

Occupation/Employer:_____ Primary Physician: _____

How did you hear about us?_____

Medication Allergies:_____

Current Medications: _____

_____

PAST AND CURRENT MEDICAL PROBLEMS

	AIDS/HIV		HEART DISEASE		STROKE
	BREATHING PROBLEMS		HEMORRHOIDS		THYROID DISORDERS – HYPER OR HYPO
	BREAST DISORDERS		HIGH BLOOD PRESSURE		OTHER
	DIABETES MELLITUS TYPE		CANCER		LAST MENSTRUAL CYCLE DATE_____
	KIDNEY FAILURE		SEIZURES – TYPE		ARTIFICIAL IMPLANTS

FAMILY HISTORY

	TYPE AND/OR WHO
CANCER	
DIABETES	
HEART DISEASE	
STROKE	
ANEURYSMS	
OTHER	

SURGICAL HISTORY

1._____ DATE:_____
2._____ DATE:_____
3._____ DATE:_____
4._____ DATE:_____

Do you smoke tobacco? Yes No If yes, how much per week? _____
Do you drink alcohol? Yes No If yes, how much per week? _____

VANCOUVER
VEIN & SURGICAL CENTER
CHRISTOPHER RUBANO, MD

PATIENT NAME:_____**DATE OF BIRTH:**_____**DATE:**_____

REVIEW OF SYSTEMS

CHECK IF YOU HAVE THESE SYMPTOMS

CHECK THIS BOX IF NO FOR ALL BELOW ☐

YES	CONSTITUTIONAL	YES	GENITOURINARY
	FEVER		NOCTURIA
	WEIGHT GAIN		INCONTINENCE
	FATIGUE		FREQUENCY
	CHILLS		PAIN WITH URINATION
	WEIGHT LOSS		BLOOD IN URINE
YES	**EARS/NOSE/MOUTH/THROAT/EYES**	**YES**	**MUSKULOSKELETAL**
	CHANGE IN VISION		LEG PAIN
	LOSS OF VISION		BACK PAIN
	HEADACHES		LEG CRAMPS
	NECK MASS		JOINT PAIN
	SORE THROAT	**YES**	**INTEGUMENTARY**
YES	**CARDIOVASCULAR**		RASH
	CHEST PAIN		CHANGE IN MOLE
	SYNCOPE		NEW MOLES
	CLAUDICATION		BREAST LUMPS
	MURMUR		NIPPLE DISCHARGE
	IRREGULAR HEARTBEAT	**YES**	**NEUROLOGICAL**
	LEG EDEMA		NUMBNESS/TINGLING
	VARICOSE VEINS		SPEECH DIFFICULTY
YES	**RESPIRATORY**		SEIZURES
	SHORTNESS OF BREATH	**YES**	**PSYC**
	COUGH		ANXIETY
	WHEEZING		DEPRESSION
	SLEEP APNEA		HALLUCINATION
	HOARSENESS	**YES**	**ENDOCRINE**
YES	**GASTROINTESTINAL**		EXCESSIVE THIRST
	VOMITING		HEAT INTOLERANCE
	CONSTIPATION	**YES**	**HEMATOLOGICAL**
	BLOOD IN STOOL		EASY BLEEDING
	LOWER CALIBER OF STOOL		EASY BRUISING
	BLACK TARRY STOOLS		LYMPH NODE SWELLING
	BLOATING		
	HEARTBURN		
	DIARRHEA		
	JAUNDICE		

VANCOUVER
VEIN & SURGICAL CENTER
CHRISTOPHER RUBANO, MD

Consent for Treatment and Acknowledgment of Receipt of Notice

Consent for Treatment: I authorize Vancouver Vein & Surgical Center, LLC (VVSCC) and its personnel to provide ongoing medical care, treatment and procedures as ordered by the physicians and/or other health care providers/ I acknowledge that no guarantee can or will be made as to the results of the care, treatment and medication prescribed.

Missed/No show Appointments: No show for regular office visit x 2 appointments will result in a $25.00 rescheduling fee. After 3rd no show, Dr. patient relationship may be terminated. No show for surgical and/or cosmetic treatment appointments (laser, Fillers, etc.) may result in a $50.00 rescheduling fee.

Financial Agreement: I understand and agree that I (or parent, if patient is a minor) am financially responsible for all services provided. I also understand that if the reason for my visit is deemed cosmetic, and therefore not covered by my insurance carrier, I am financially responsible for the cost of this visit and/or treatment. As a courtesy VVSC will bill my insurance carrier. Regardless of outstanding insurance claims, full payment of outstanding balances is due within 90 days of the date of service. If my account is referred to a collection agency, I understand that I am responsible for reasonable collection expenses, including attorney's fees.

Assignment of Benefits: I authorize my insurance benefits to be paid directly to VVSC. I certify that all information given in applying for payment under the Social Security Act or other health insurance plan is correct and authorize verification of coverage by VVSC. A photocopy of this authorization shall be considered as effective and valid as the original.

Insurance Coverage and benefit Verification: I understand that it is my responsibility to verify with my insurance company that I have active coverage and that VVSC is contracted with my insurance carrier. I also understand that it is my responsibility to make pacific VVSC aware of any required authorization by my plan for any office visits and/or procedures.

Medicaid Members Financial Agreement: It has been explained to me that VVSC is not a contracted provider with DSHS-Medicaid. I understand that Medicaid will not be billed and any remaining balance after my primary insurance has been billed is my financial responsibility.

Consent to Release of Information: I authorize VVSC to release to my insurance carrier(s), including Medicare, Medicaid and any other reimbursing agency, information about my identity, treatment, diagnosis, prognosis and/or services rendered (including drug and alcohol abuse treatment, mental health treatment, diagnosis and/or treatment of HIV/AIDS-related illness or sexually transmitted disease) as permitted by state and federal law which may be required or requested, thus releasing VVSC from any liability for furnishing such information. I understand information may be released through electronic or paper media.

Notice if Health Information Practices: I acknowledge that I have been provided with a copy of the Notice of Privacy Practices.

_____ _____
Signature of Patient or Legally Authorized Representative Date

Name and Relationship:_____ _____
to patient, if not signed by patient Date