Bill K. Chang MD, FACS

Vascular and Endovascular Surgery

PATIENT REGISTRATION

NAME: _____ DOB: _____/_____/_____

SS # _____/_____/_____ EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE :(_____) _____ CELL PHONE :(_____) _____

EMPLOYER: _____ PHONE :(_____) _____

EMPLOYER ADDRESS: _____

CONSENT TO RELEASE MEDICAL INFORMATION TO:

I hereby authorize Bill K. Chang, MD, FACS to release and/or disclose any information contained in my medical record to the person(s) listed:

Name: _____ Relationship to Patient: _____ Phone Number: _____

Name: _____ Relationship to Patient: _____ Phone Number: _____

Emergency Contact:

Name: _____ Relationship to Patient: _____ Phone Number: _____

CAN WE LEAVE MESSAGES WITH YOUR EMERGENCY CONTACT? ____YES ____NO

Advance Directive:

Do you have an advanced directive (living will/power of attorney)? ___YES ___NO
If yes, please provide a copy for your medical chart.

PHARMACY NAME: _____ PHARMACY PHONE: _____
PHARMACY ADDRESS: _____

HOSPITAL PERFERANCE:

- □ HCA CL
- □ MMC

Primary Care Physician: _____ ***Referring Physician:*** _____

Nephrologist: _____

Dialysis Center: _____ ***Dialysis Days:*** ___ ***MWF*** ___ ***TTS***

Cardiologist: _____

_____ _____
Patient Signature Date

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COMPREHENSIVE HISTORY

PAST MEDICAL HISTORY

Please *mark* if you have any of the following medical illnesses:

- □ PVD / PAD
- □ Chronic Kidney Disease (CKD)
- □ Arthritis
- □ Asthma
- □ Diabetes
- □ Anemia
- □ Pacemaker
- □ Clot in lungs (PE)
- □ Clot in legs (DVT)
- □ Depression / Anxiety
- □ Thyroid Disease
- □ Heart Attack
- □ High Blood Pressure
- □ Stroke / TIA
- □ Lymphedema
- □ Hepatitis B or C
- □ HIV / AIDS
- □ Neuropathy
- □ Restless Legs
- □ A-Fib
- □ Coronary Artery Disease (CAD)
- □ COPD
- □ Back Pain
- □ Dizziness
- □ Aneurysm (type): _____
- □ Cancer (type): _____

PAST SURGICAL HISTORY

Please list surgeries from the last 10 years:

_____
_____
_____
_____
_____

FAMILY HISTORY

MOTHER

- □ Deceased
- □ Alive
- □ High Blood Pressure
- □ Diabetes
- □ Coronary Artery Disease
- □ Peripheral Artery Disease
- □ Cancer (type): _____
- □ Other: _____

FATHER

- □ Deceased
- □ Alive
- □ High Blood Pressure
- □ Diabetes
- □ Coronary Artery Disease
- □ Peripheral Artery Disease
- □ Cancer (type): _____
- □ Other: _____

SIBLINGS

- □ High Blood Pressure
- □ Diabetes
- □ Coronary Artery Disease
- □ Peripheral Artery Disease
- □ Cancer (type): _____
- □ Other: _____

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SOCIAL HISTORY

- □ Current Smoker
  How often do you smoke cigarettes? ____Everyday ____Some days
- □ Former Smoker
  How long did you smoke? _____ When did you quit? _____
- □ Nonsmoker
- □ Other tobacco user (type): _____
- □ Other drugs not prescribed by a physician (type): _____

Did you have a drink containing alcohol in the past year? ___ Yes ___ No
If yes, how often? _____

Caffeine Intake:

- □ None
- □ 1-2 cups per day
- □ 2-3 cups per day
- □ 3-4 cups per day
- □ More than 4 cups per day

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Do you exercise? ___ YES ___ NO
If so, what type of exercises do you do? _____

VACCINATIONS
Have you had your flu vaccination for this season? ___ YES ___ NO
If yes, please provide the date given: _____

Have you had your pneumonia vaccine within the last 5 years? ___ YES ___ NO
If yes, please provide the date given: _____

MEDICATION ALLERGY
Please list any medication allergies you may have as well as the type of reaction.
_____
_____
_____

MEDICATIONS
Please list all medications you are currently taking:

NAME OF MEDICATION	DOSAGE (mg, gm, tsp)	HOW MANY TABLETS PER DOSE?	FREQUENCY

AUTHORIZATION TO RELEASE INFORMATION

I have received and will review the Notice of Privacy Practices given to me on my first visit to Bill K. Chang, M.D. and understand additional copies are available upon request. I authorize Bill K. Chang, M.D. to furnish any consulting physician, physician of my request, or insurance company, and its representative, any information or copies of all hospital, medical records, consultations, and prescriptions relating to specific illness or injury. A copy of this authorization shall be effective and valid.

INITIAL _____

AUTHORIZATION FOR BILLING

I authorize direct payments to Bill K. Chang, M.D. the insurance benefits otherwise payable to me, but not to exceed my indebtedness to said organization on the account of charges listed herein. A copy of this authorization shall be effective and valid. I understand that I am responsible for any remaining balance my insurance company does not pay. I understand my office visit co-pay is due at the time of service unless other arrangements have been made.

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INITIAL _____

GENERAL CONSENT FOR TREATMENT

I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to consultation, examination, and care and to consider such medical, surgical or other services to me necessary under the general and specific instructions of the surgeon and his assistant or his designee as is necessary in his judgment. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of consultation, examination and care by Bill K. Chang, M.D.

INITIAL _____

MISSED APPOINTMENTS

I understand the office of Bill K. Chang, M.D. reserve the right to cancel my appointment if I am more than 15 minutes late, to be rescheduled to the next available appointment date/time. I also acknowledge that if I do not cancel my diagnostic testing appointment within 24 hours, I will be charged $50 fee. If I do not give a 24-hour notice in my office visit appointment I will be charged $25 fee.

INITIAL _____

E-PRESCRIBING CONSENT

I hereby provide informed consent to Dr. Bill K. Chang, M.D. to enroll me in the ePrescribe program (send electronic prescriptions). I have had an opportunity to ask questions and all my questions have been answered to my satisfaction.

INITIAL _____

_____ _____

Patient Signature Date

VASCULAR HISTORY

Name:	Date of Birth:

Please mark if you experience any of the following symptoms in your legs:

- € Leg pain
- € Restless legs
- € Skin discoloration
- € Bleeding from veins
- € Rash / redness
- € Numbness
- € Bulging veins
- € Swelling
- € Burning
- € Heaviness
- € Cramping
- € Dry skin
- € Tingling
- € Spider veins
- € Itching
- € Leg fatigue
- € Cellulitis (leg infection)
- € Weakness
- € Open wounds (current or past)
- € Decreased / increased sensitivity
- € Other: _____

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Please mark the *daily activities affected* by the symptoms in your legs:

- € Walking
- € Exercise
- € Shopping
- € Cleaning
- € Cooking
- € Showering
- € Job Functions
- € Other: _____

How long have you experienced these symptoms? _____

How long have you had the ulcers / open wounds? (if applicable) _____

Please mark any methods you have used to relieve your leg discomfort / symptoms:

- € Compression stockings
- € Exercise
- € Leg elevation
- € Warm soaks / heating pad
- € Cold packs
- € Sitting down
- € Massage
- € Pain medication
- € Other: _____

Have you ever worn medical grade compression stockings? ___ Yes ___ No
If yes, when? _____ and for how long? _____

Have you ever had any vein procedures? ___ Yes ___ No
If yes, by whom? _____ When? _____

By which of the following methods:

- € Radiofrequency Ablation (RFA)
- € VenaSeal
- € Laser Treatment
- € Vein Stripping
- € Cosmetic injections

HAVE YOU EVER HAD AN ALLERGIC REACTION TO:

- □ Fake nails
- □ Fake eyelashes
- □ Dermabond
- □ Band-Aids
- □ Super Glue
- □ Adhesive

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PATIENT-PROVIDER AGREEMENT (PPA) for Opioid Treatment

The use of opioids (morphine-like drugs) is only part of pain treatment. Opioids can be very useful but can also cause serious problems and are not always effective in the treatment of pain. The purpose of this agreement is to outline the safest manner to prescribe opioids.

The goals for using this medicine are:

- To improve daily functional activities and/or the ability to work.
- To decrease the intensity of pain.

Provider Responsibilities

- To explain to me the risks and benefits of using opioids for pain.
- To explain alternative or complementary therapies for pain management.
- To check the Prescription Monitoring Program to see what medications I may be prescribed by other providers.
- To communicate with me any concerns regarding my use of opioid medications.
- If needed, and in collaboration with me, to work with other specialists to ensure I am receiving effective pain treatment. This may include referral to addiction treatment if opioids become a problem for me.
- To protect the confidentiality of my health care and prescription information to the extent authorized by law

Patient Responsibilities

I understand and commit to the following for the best treatment of my pain and safest use of opioids:

- Follow my treatment plan.
- Tell my provider all the medication that I take.
- Communicate with my provider how I am doing, such as, daily functions, pain level, and side effects
- Obtain opioids from one provider (or provider group) only.
- Take medications exactly as prescribed.
- Not use medicine that has not been prescribed to me or use street drugs.
- Not use alcohol with this medicine unless my provider says it is safe to do so.
- Secure my medicine so no one else can take it. Safely dispose of unused medicine. Not share, sell, or trade my medicine.
- My medicine will not be replaced if it is lost, stolen, damaged or used-up sooner than prescribed.
- Refills will be: 1) filled through only one pharmacy; 2) must have had an office visit within 90 days of refill request; 3) please note, some insurances only allow a 7 day supply of opioid medication at a time

In the event I have problems taking opioid medication:

Taking opioids other than prescribed can result in serious complications including addiction and overdose. If it occurs that I demonstrate signs of misuse or addiction, my provider may require that I provide a urine sample for toxicology screening at random times. Under these circumstances, I agree to participate in random toxicology screening. If complications arise as a result of taking opioids that my provider does not feel comfortable treating, he may consult with other specialists and make appropriate referrals. Finally, if my provider believes the medications are causing more harm than help, he may stop the medication in a safe way.

I have been told about the possible risks and benefits of this medication

- The medication may help my problem but may cause other problems like addiction, overdose and death.
- When to start the medication and how to dispense daily.
- I understand if I drink alcohol or use street drugs, I may not be able to think clearly. I could become sleepy and have an accident.
- I may get addicted to this medicine. This could cause personal and legal problems and problems at home or work.
- If I or anyone in my family has a history of drug or alcohol problems, I will have a higher chance of addiction to this medicine.
- If I take this medicine every day, my body will get used to it. I may get sick if I stop the medicine all at once.

I have talked about this agreement with my provider, and I understand it. I have had an opportunity to ask questions about the potential benefits and risks of this medicine.

Print Name	Signature	Date
Provider's Signature		Date

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