

Initial Clinical History Intake Form

Date: _____

Patient Information English/Spanish

Name: _____ Date of Birth: ___ / ___ / ___

Reason For Visit: _____ **Referring Doctor:** _____

HEIGHT _____ **WEIGHT** _____

Your Medical Team

Primary Doctor:	Nephrologist/Kidney Doctor:	Podiatrist/foot Doctor:
Cardiologist/Heart Doctor:	Wound Care:	Other:

Past Medical History (Please check all that apply)

<input type="checkbox"/> None <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke/TIA/Mini stroke <input type="checkbox"/> Heart Attack <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Depression <input type="checkbox"/> Obstructive Sleep Apnea <input type="checkbox"/> Other: _____	<input type="checkbox"/> Anxiety <input type="checkbox"/> Bleeding Difficulties <input type="checkbox"/> Hepatitis A B or C <input type="checkbox"/> HIV <input type="checkbox"/> PAD <input type="checkbox"/> VENOUS INSUFFICIENCY <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer: _____	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Seizures <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Arthritis (type) _____ <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> TB <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Dialysis (type) _____
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Past Surgical History (type and year)

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Prescription Medications (Name and Dose/Number per day)

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____
7. _____	8. _____

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9. _____

10. _____

NAME: _____

Non-Prescription Medications (Name and Dose/Number per day)

1. _____

4. _____

2. _____

5. _____

3. _____

6. _____

Do you have:

- Fever/Chills Shortness of Breath Chest Pain

Drug Allergies and Type of Reaction

No Known Drug Allergies 1. _____ 3. _____

Latex Shellfish 2. _____ 4. _____

Tape Iodine/Contrast Other: _____

Social History (Please check appropriate listings)

Tobacco Use

Never
Quit/When? _____
Cigarettes/Pack per day? _____
Pipe
Cigars
Chewing Tobacco

How many years? _____

Alcohol Use

None
Socially
Daily

Heavy

Have you ever been treated for alcoholism?
Yes _____ No _____
If yes, when? _____

Drug use

None
Marijuana
Amphetamines

Other _____

Have you ever been treated for drug use?
Yes _____ No _____
If yes, when? _____

Family History

Father	Living Deceased	Age: _____	Medical History or cause of death	___ Blood pressure ___ Diabetes ___ Cholesterol ___ Cancer/Type ___ Other _____
Mother	Living Deceased	Age: _____	Medical History or cause of death	___ Blood pressure ___ Diabetes ___ Cholesterol ___ Cancer/Type ___ Other _____

Espada Vascular

Print

Name: _____

Consent and Disclosure

Consent to Treat: I understand that as a patient I have the right to make all decisions regarding my care. I voluntarily request Dr. Jeffrey Martinez, as my treating Physician, and associates of Espada Vascular, such as, a Physician Assistant/Nurse Practitioner, RN/LVN, technical assistants and other health care providers as deemed necessary, to treat my condition. I also understand that no warranty or guarantee has been made to me as to results or cure. I understand that my Physician and/or Physician Assistant may discover other or different conditions which require additional or different procedures than those planned. I authorize my Physician and/or Physician Assistant to perform such other procedures which are advisable in their professional judgment.

Specific Surgical/Diagnostic Procedures: _____

Risk and Emergency: Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the treatment.

Electronic Communication/Messaging: I authorize Espada Vascular to send communication via text message and/or by email.

Authorization to Release Information: I authorize Jeffrey Martinez, MD to release any and all healthcare information as necessary to (a) obtain payment from my Payers for my healthcare, (b) to conduct utilization review, peer review, and quality assurance, and (c) to other healthcare providers that will assist with my care. I understand that this information will identify me and may relate to my history, diagnosis, treatment, or prognosis; it will also include, where applicable, psychiatric, alcohol abuse, drug abuse, specific laboratory results of HIV, or the diagnosis of AIDS. I understand that in the event of a healthcare worker being exposed to my blood or bodily fluids, my blood may be tested for the HIV antibody and other communicable diseases.

Financial Authorizations: I authorize all payers to directly pay Jeffrey Martinez, MD for services provided. I assign to Jeffrey Martinez, MD my right to receive payment from third-party payers. Third-Party payers include anyone from whom benefits are or may become payable to me for services provided.

Receipt of Information: I acknowledge that I have received the "Notice of Privacy Practices" and a copy of "Patients' Rights, Responsibilities and Healthcare Choices" from Jeffrey Martinez, MD. I certify this has been fully presented and explained to me, that I have read it or have had it read to me, and that I understand its contents.

Financial Responsibilities: I understand and agree that I am responsible for payment of all charges that result from the care provided to me. I agree to pay these charges including payments not paid by my insurance company payers within 120 days. I understand that it is my responsibility to submit accurate insurance information on all dates of service and to comply with all requests of my insurance company within a timely manner to ensure payment is made within 120 days. I understand that if I am covered by Medicare/Medicaid, my obligation under this section may be limited by law. All payments, including co-payments, co-insurance, and deductibles, are due at the time services are rendered. I understand if balances on my account are not paid in a timely manner, they may be transferred to a third party for collections or further actions.

Medication History: I authorize Medication History Retrieval from the National database.

Property: I understand that Jeffrey Martinez, MD does not assume responsibility for any personal property.

No Show/Late Appointment Policy: I understand that 24 hours' notice is required for appointment cancellations and that cancellations can and must be left on voicemail if after hours. I understand and agree to a \$50 standard appointment no-show fee, and/or a \$100 procedure no-show fee. All no-show fees are to be collected prior to the next scheduled appointment or before services are rendered. Workers' Compensation patients will be personally responsible for these amounts. After 3 No Shows on record, we reserve the right to conclude our relationship for noncompliance with the stated office policy. If you are more than 15 minutes late for your scheduled appointment, you may need to reschedule your appointment.

Request for forms: Due to the quantity and complexity of the forms requested, there will be a \$10 charge, payable in advance, for the completion of each of the first two forms requested. There will be a \$25 charge for all additional forms.

Sunshine ACT Disclosure: In compliance with the Sunshine Act, a provision of the Affordable Care Act, we wish to disclose that our office occasionally receives food and beverages, sample drugs and patient coupons, and promotional material from pharmaceutical vendors and/or manufacturers in conjunction with product education. We do not receive direct financial compensation from any of our vendors. By initialing here, you acknowledge this disclosure.

PATIENT/ OTHER LEGALLY RESPONSIBLE PERSON (signature required): By signing, you certify that this form has been fully explained to you, that you have been given the opportunity to ask questions, and that you fully understand its contents.

Signature: _____ Date and Time: _____

Witness:

Name: _____ Relationship _____



Jeffrey M. Martinez, M.D.

7500 Barlita Blvd., Ste. 107
San Antonio, TX 78224
P: 210-540-6766 F: 210-903-8044

Authorization to Release or Obtain Medical Records

I, _____ DOB: _____ Authorize:
Patient's Name (Please Print)

Jeffrey M. Martinez, MD, PA
7500 Barlita Blvd., Ste. 107
San Antonio, TX 78224
(P) 210-540-6766 (F) 210-903-8044

Or Other (specify below)

Name of Person or Facility: _____
Address: _____
City: _____ State: _____ Zip: _____

To release information to:

To Obtain information from:

Name of Person of Facility: _____
Address: _____
City: _____ State: _____ Zip: _____

Purpose of this Authorization: _____

I authorize the release of the following protected health information:

(Place an "X" in the box(es) that apply to this information you want released or want to obtain)

For personal copies of your medical records the cost will be \$25.00 for the first 25 pages and .25 cents for each page thereafter. Please allow 15 business days from day of request to process your request for medical records.

Entire record Consultation notes/report Lab reports X-Ray reports Surgical reports

Medical History, Examination reports Treatment or Test Hospital records including reports

Other: _____

Patient Signature: _____ Date: _____

Witnessed by: _____ Date: _____



PATIENT DEMOGRAPHICS

Date: _____

Patient Information

English/Spanish

E-mail: _____

Name: _____ Age: _____ Date of Birth: ___ / ___ / ___

Address By: He/Him/Mr. She/Her/Ms./Mrs.

Race: Caucasian African American Asian Hispanic Multi-Racial

Other: _____

Sex: Male Female

Marital Status: Single Married Divorced Widowed #Children: _____

Primary Doctor Full Name/Number: _____ Referring Doctor Name: _____

PHARMACY PHONE #: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____