SAMB Surgical Associates of Monterey Bay

Vein Clinic OF MONTEREY BAY, INC.

office use only

PATIENT INFORMATION

Name_____ Age_____ M / F

Address_____ Birth Date_____

City _____ State _____ Zip Code __ __ __ __ __ - __ __ __ __

Email Address: _____

Social Security Number_____ Home Phone #_____

Employer_____ Work Phone #_____

Occupation_____ Cell Phone #_____

Preferred Language _____ Pager #_____

Ethnicity _____ Preferred Pharmacy _____/Laboratory_____

Emergency Contact_____Emergency Contact Phone #_____

Referred By _____ Phone #_____

Primary Care Physician_____Phone #_____

(Circle One) Married Domestic Partner Divorced Separated Single Widowed

Spouse/Parent Name_____ Spouse/Parent Home Phone #_____

Spouse/Parent Employer_____ Spouse/Parent Work Phone #_____

MEDICAL INSURANCE INFORMATION

Please complete even if we have your insurance card(s)

HMO_____ PPO_____ Worker's Comp_____ Medicare/Medi-Cal _____ Cash Pay _____

Primary Insurance _____

Name of Subscriber _____ Relationship to Patient _____

Subscriber's Date of Birth _____ Subscriber's Social Security Number _____

Secondary Insurance Name_____

Name of Subscriber _____ Relationship to Patient _____

Subscriber's Date of Birth _____ Subscriber's Social Security Number _____

PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST TO COPY

I attest that the information provided is true and correct to the best of my knowledge. I hereby authorize medical providers of the Surgical Associates of Monterey Bay to release to the insurance company any information pertaining to my care, including diagnosis and medical records for the purposes of reimbursement. I hereby assign the insurance company to pay directly to Surgical Associates of Monterey Bay any benefits due for services provided. I authorize Surgical Associates of Monterey Bay to electronically coordinate my medication history with national pharmacy systems for purposes of rendering treatment.

Signature_____ Date_____

Surgical Associates of Monterey Bay

Patient Information

Name_____Phone number_____
Today's date_____Date of birth_____Age_____Height _____Weight_____

Medical History

Your regular physician_____
Other doctors who have treated you_____
List all medical illnesses you have had

_____
_____
_____

List all operations or procedures you have had **Approximate date** **Hospital**

_____
_____
_____
_____

List any medications you take (include prescription, over-the-counter, *and* naturopathic (herbal)

PLEASE USE ATTACHED PATIENT MEDICATION LIST **IF NONE CHECK HERE** ☐

Are you allergic to any medications? ☐No ☐Yes Please list:_____

_____

Are you allergic to eggs, seafood, soy, or latex? ☐No ☐Yes _____

Family History

List age of family member *and* any medical problems (Diabetes, cancer, heart disease, e.g.)
Mother _____Sisters_____
Father _____Brothers_____
Sons _____Daughters_____

Social History

Occupation_____

Y N
☐ ☐ Do you smoke? If yes, how many packs per day?_____How many years?_____
☐ ☐ Do you drink alcohol? If yes, how many drinks per week?_____
☐ ☐ Do you drink coffee, tea or other caffeinated beverage? If yes, how many cups per day?_____

Health Review *Have you ever had…*

Y N
☐ ☐ Recent unexplained weight loss?
☐ ☐ Eye problems (vision changes/glaucoma/cataracts, e.g.)?
☐ ☐ Dental problems?
☐ ☐ Sinus infections/congestion?
☐ ☐ Chest pain? Angina?
☐ ☐ Heart attack?
☐ ☐ High blood pressure?
☐ ☐ Other heart problems (palpitations, valve disease, e.g.)?
☐ ☐ A test of your heart function?
☐ ☐ Asthma or wheezing?
☐ ☐ Chronic coughing? Shortness of breath at rest?
☐ ☐ Heartburn or reflux?
☐ ☐ Chronic abdominal pain?
☐ ☐ A colonoscopy or barium enema?
☐ ☐ Chronic constipation or diarrhea?
☐ ☐ Liver problems or jaundice?
☐ ☐ Black or bloody stools?
☐ ☐ Kidney stones?
☐ ☐ Blood in your urine?
☐ ☐ Bladder of kidney infections?

Y N
☐ ☐ Muscle or joint problems?
☐ ☐ Back or neck problems?
☐ ☐ Skin diseases or unusual rashes?
☐ ☐ Breast problems or diseases?
☐ ☐ Strokes or episodes of numb/weakness?
☐ ☐ Dizziness or fainting spells?
☐ ☐ Seizures?
☐ ☐ Chronic headaches?
☐ ☐ To see a psychiatrist?
☐ ☐ Diabetes?
☐ ☐ Thyroid or parathyroid problems?
☐ ☐ Bleeding or clotting problems?
☐ ☐ Anemia (low blood counts)?
☐ ☐ Exposure to HIV or hepatitis viruses?
☐ ☐ Weakness in your immune system?
☐ ☐ Other medical problems? _____

_____

☐ ☐ Could you be pregnant today?
How many times have you been pregnant?_____
Live births ____Miscarriages_____Abortions____
How old were you at your first child?_____
Did you breastfeed?____How many months?____
Age at first menstrual period?_____
Date of last menstrual period_____

SAMB Surgical Associates of Monterey Bay
831.464.9962

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Medication List

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Name	Dose	# Times Daily