New Patient Information

Name:____

DOB:_______________________________________SSN # ____________________

Street Address:____

City:_______________________________ State:_______________ Zip: ____________

Phone Number:____________________ Alternate Phone Number:___________

Race:__________________ Language Spoken:______________

Marital Status: Married Single Divorced Widowed Partner

Email: ____

Emergency Contact Name: __________________________ Relationship:_____________

Phone Number:_______________

Primary Care Physician:_______________________ Referring Physician:________________

Advanced Directive ☐ Organ Donor ☐ Living Will ☐ None ☐

HIPPA ACCESS FORM FOR PROTECTED HEALTH INFORMATION

i Understand that it is the policy of Vein and Vascular of Dothan dba Jason Beaver MD LLC to restrict access to my protected health information. I understand that my medical records will be accessed by the caregiver(s) providing health services, and my insurance company for the payment of my claim(s). I understand that the following person/people listed will have access to my private health care information

Patient Name: ______________________________ DOB:_________________

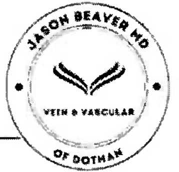
Name:	Relationship	Phone Number

Patient Signature: ______________________________ Date:_________________

Witness Signature: ______________________________ Date:_________________

By signing below, either personally or through the person legally empowered to give consent, I authorize this office, its employees' agents and other affiliates to provide general care for this and all subsequent requests for care. I hereby authorize this office of Vein and Vascular of Dothan dba Jason D Beaver MD LLC to release medical information required during examination and treatment and permit payment directly to them and benefits due for their services rendered. I recognized and accepted responsibility for services rendered regardless of insurance coverage. I understand it is my responsibility to contact the practice with any additions from my original authorization for disclosure of Protected Health Services

Patient History



Name: ______________________________ DOB:______________

____ Acid Reflux	____ Cancer Type:	____ Hepatitis	____Liver Disease
____ Alcoholism	____ Colitis	___ High Blood Pressure	____Lung Disease
____ Anemia	____ Diabetes	____ High Cholesterol	____Osteoporosis
____ Arthritis	____ Diverticulitis	____ HIV/ AIDS	____Stroke
____ Asthma	____ Emphysema	____ Irritable Bowel	____Thyroid Disease
____ Atrial Fibrillation	____ Epilepsy/ Seizures	____Depression	____Other Explain:
___ Bleeding Disorder	____ Heart Disease	____Kidney Disease	____Other Explain:

Previous Surgeries-

List all part surgeries and approximate Date:

Medication Allergies:

____

____

____

NO KNOWN DRUG ALLERGIES ☐

MEDICATIONS:

Please list medication names and dosages or you can provide a list

FAMILY HISTORY:

Please Circle all that apply

Cancer	Mother Father Sister Brother Son Daughter Grandparents
Heart Disease	Mother Father Sister Brother Son Daughter Grandparents
Kidney Disease	Mother Father Sister Brother Son Daughter Grandparents
Diabetes	Mother Father Sister Brother Son Daughter Grandparents
Hypertension	Mother Father Sister Brother Son Daughter Grandparents

SOCIAL HISTORY-

Check which of the following applies to you

Smoking: _____ Current _____ Former _____ Never

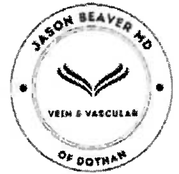
Alcohol: ____Yes ____No

Other Substance: _____Yes _____ No

Have you had a fall in the past year? _____Yes _____ No

Patient Signature: ______________________________ Date:______________

To all current and new patients



Dr. Beaver has privileges at Flowers hospital.

We have a relationship with Dr. Jeffery Whitehurst at Southeast Health for any of our patients who need inpatient treatment if for any reason Dr. Beaver is unavaliable

We also have a relationship with Dr. Osman at Southeast Health and Dr. William Veale in Montgomery/ Troy for any vascular issues that need to be addressed in a hospital setting.

Thank you, Jason D Beaver MD

Policy Statement:

I hereby agree and consent as follows: if my account becomes delinquent it will be placed with Prim & Mendheim, LLC, for collection and subject to the following terms regarding any outstanding balance that I owe: (1) I will incur interest at the rate of one and one-half (1½) percent per month (18% per annum); (2) in addition to the outstanding balance, I will be responsible for reasonable collection costs, attorney's fees, and costs of court incurred in the collection of same, whether such outstanding balance is satisfied prior to or after initiation of a lawsuit, or after a judgment has been entered in a lawsuit; and (3) any lawsuit or legal proceeding resulting from the outstanding balance and debt shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and objections to said jurisdiction. By signing below, I affirmatively acknowledge that I have read the same before signing. Furthermore, I can be contacted regarding my balance on my cell phone and I hereby waive any and all state and federal personal property exemptions, wage exemptions, and homestead exemptions of my state of residence and state of operation in the event of judgment, levy, or garnishment. Finally, if I reside in Florida I hereby waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance.

Print Patients Name:______________________________ Date:____________

Patients Signature:______________________________ Date:____________