PLEASE PRINT

PATIENT REGISTRATION

DATE	NEW	ADD	CHANGES

ACCOUNT NUMBER	LAST NAME	FIRST NAME	MI

STREET ADDRESS	APT #	CITY, STATE	ZIP CODE

SEX	BIRTH DATE	SOCIAL SECURITY NUMBER	HOME TELEPHONE NUMBER	CELL PHONE NUMBER
			(AREA)	(AREA)

INSURANCE COMPANY (PRIMARY)			INSURANCE COMPANY (SECONDARY)		
NAME			NAME		
INSURANCE COMPANY ADDRESS			INSURANCE COMPANY ADDRESS		
MEMBER OR MEDICARE NUMBER	GROUP NUMBER		MEMBER/POLICY NUMBER	GROUP NUMBER	
SUBSCRIBER'S NAME (IF NOT PATIENT)	DATE OF BIRTH	REL	SUBSCRIBER'S NAME (IF NOT PATIENT)	DATE OF BIRTH	REL

PHARMACY	
NAME	TELEPHONE NUMBER
ADDRESS	
CITY, STATE	ZIP CODE

PRIMARY CARE PHYSICIAN	
NAME	TELEPHONE NUMBER

REFERRING PHYSICIAN	
NAME	TELEPHONE NUMBER

NURSING OR ASSISTED LIVING FACILITY
DO YOU LIVE IN ANY TYPE OF NURSING OR ASSISTED LIVING FACILITY? __ YES __ NO IF YES, WHERE?

EMERGENCY NOTIFICATION			
TELEPHONE (AREA)	NAME		RELATIONSHIP
CELL PHONE (AREA)	STREET ADDRESS	CITY, STATE	ZIP CODE

Conejo Valley Vascular Associates

Name: _____ Date of Birth: _____

Physician being seen: _____ Date of Visit: _____

Reason for today's visit: _____

PAST MEDICAL HISTORY

Please check any of the following health problems you have had or have now:

__ High Blood Pressure
__ High Cholesterol
__ Heart Attack
__ Irregular Heartbeat (A-Fib)
__ Congestive Heart Failure (CHF)
__ COPD
__ Asthma
__ Pneumonia
__ History of Covid-19
__ Stroke (or Mini-Stroke)
__ Aneurysm; location _____
__ Peripheral Vascular Disease (PVD)
__ Deep Vein Thrombosis (DVT)
__ Pulmonary Embolism (PE)
__ Bleeding Disorder
__ Anemia
__ Hepatitis
__ HIV/ AIDS

__ Diabetes
__ Kidney Failure
__ Liver Problems
__ Thyroid Disorder: Type _____
__ Gastric Reflux (GERD)
__ Stomach Ulcers
__ Ulcerative Colitis / Crohn's
__ Prostate Problems
__ Varicose Veins
__ Peripheral Neuropathy
__ Peripheral Artery Disease (PAD)
__ Osteoarthritis
__ Osteoporosis
__ Cataracts
__ Seizure Disorder
__ Alzheimer's Disease
__ Cancer: Type _____

Other: _____

_____

PAST SURGICAL HISTORY (Please list all previous surgeries)

_____

_____

_____

_____

_____

_____

_____

Name: _____ Date of Birth: _____

HABITS

Do you smoke tobacco? __ No __ Yes: __ packs per day for __ years

Have you smoked in the past? __ No __ Yes: __ packs per day for __ years

Do you drink alcoholic beverages? __ No __ Yes: __ drinks per day

Do you use any recreational drugs? __ No __ Yes: What? _____

How often? _____

Do you exercise regularly? __ No __ Yes

SOCIAL/FAMILY HISTORY

Your occupation: _____

Are you: __ Married __ Divorced __ Widowed __ Single

Immediate-family members:

Father: __ Alive, age ____ __ Deceased at age ___ cause _____

Mother: __ Alive, age ____ __ Deceased at age ___ cause _____

Brothers: __ No __ Yes, how many _____

Sisters: __ No __ Yes, how many _____

Children: __ No __ Yes, how many _____

Have you been vaccinated for Covid-19? __ Yes __ No

DIALYSIS INFORMATION (If applicable)

Type - circle one: HEMO-DIALYSIS PERITONEAL (PD)

Days - circle days: Mon Tues Wed Thurs Fri Sat

Dialysis Center: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Nephrologist: _____

MEDICATION LIST

Name: _____ Date of Birth:_____

PLEASE LIST YOUR CURRENT MEDICATIONS & OVER THE COUNTER MED/SUPPLEMENTS

MEDICATIONS	DOSAGE	FREQUENCY

ALLERGIES Please list all medication allergies with reaction

_____

_____

_____

_____

_____

_____

TRUNG D. BUI, M.D.
Vascular & Endovascular Surgery
2220 Lynn Road, Suite 102
Thousand Oaks, CA 91360
(805) 496-9727

Assignment of Benefits

I hearby assign all medical and/or surgical benefits to which I am entitled, including major medical benefits, Medicare, private insurance and any other health insurance plan, to Dr. Trung D. Bui, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I am also aware that a service fee of 1% per month of my outstanding balance may be added to my account if I cannot pay my account in full, or at least make regular monthly payments. I hearby authorize said assignee to release all information necessary to secure payment.

Signed:_____ Date: _____

TRUNG D. BUI, M.D.
CARNEY CHAN, M.D.
Vascular & Endovascular Surgery
2220 Lynn Road #102 - Thousand Oaks, CA 91360
(805) 496-9727 - Fax# (805) 496-9148

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient bas the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

This Consent was signed by: _____
Sign and Print Name - Patient or Representative

Relationship to Patient (if other than patient): _____

In Front of: _____ Date: _____
Sign and Print Name - Practice Representative

Patient Portal Authorization Form

Protecting Your Private Health information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system Is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) The secure message must reach the correct email address, and
2) Only the correct individual (or someone authorized by that Individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It Is imperative that our practice has your correct e-mall address and that you Inform us of any changes to your e-mail address.**

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change It.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth hereln, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may Impose to communicate with patients via online communications. I understand and agree with the Information that I have been provided.

Secure Email Address: _____

Print name: _____ DOB: _____

Patient Signature: _____ Date: _____

❑ Refused

Complete the following If the email address does not belong to the patient: Please note, portal access is not available for patients aged 13-18 years.

Name of Parent/Guardian requesting access:

_____

Late Name Middle Initial First Name

_____

Relationship to the Patient Date

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Patient Portal Authorization Form

Purpose of this Form:

The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email you will be assigned a username and password. After you registered with the Patient Portal you will be allowed the following:

- Request your own appointments
- Check status of your scheduled appointment
- Review lab results
- Request a prescription refill
- Complete the Medical History Forms
- View Messages sent by the Clinic

The following will NOT be accepted through Patient Portal:

- Receiving advice on the best course of treatment for your medical problem. All diagnosis will be made by your provider when you are seen for an office visit.
- Request for narcotics/controlled medications.
- Request for refill for medication not currently being prescribed by our physicians

Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted In transmission between the website and your computer.

continued...

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To All Patients:

In order to bring our records into compliance with the Medicare Electronic Health Record Initiative Program, we need to update the following information for all of our patients. You will only be asked to complete this form one time.

Thank you.

Gender:

- ❑ Male
- ❑ Female

Race:

Please indicate your race

- ❑ American Indian or Alaskan Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Decline to Specify

Ethnicity:

- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Decline to Specify

Print Name: _____ Date of Birth: _____