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.

EMPLOYMENT INFORMATION OF SUBSCRIBER	
EMPLOYER'S NAME	WORK TELEPHONE (AREA)
STREET ADDRESS	OCCUPATION
CITY, STATE	ZIP CODE

PATIENT'S EMPLOYMENT	
EMPLOYER'S NAME	WORK TELEPHONE (AREA)
STREET ADDRESS	OCCUPATION
CITY, STATE	ZIP CODE

REFERRING PHYSICIAN	
NAME	TELEPHONE (AREA)

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

Alan C. Mintz, M.D. *Trung D. Bui, M.D.*
Vascular & Endovascular Surgery
2220 Lynn Rd. #306 • Thousand Oaks, CA 91360

PAST MEDICAL HISTORY

Name:_____ Today's date:_____

☐ Male ☐ Female Date of birth:_____ Place of birth: _____

REASON FOR TODAY'S VISIT:_____

_____

PAST ILLNESSES: _____

_____

_____

PREVIOUS SURGERIES: _____

_____

_____

PREVIOUS HOSPITALIZATIONS: _____

_____

_____

MEDICATIONS (including vitamins and herbal products): _____

_____

_____

ALLERGIES (with type of reaction): _____

_____

_____

HABITS:

Do you smoke tobacco? ☐ No ☐ Yes:____packs/day for_____years

Have you smoked in the past? ☐ No ☐ Yes:____packs/day for_____years

Do you drink alcoholic beverages? ☐ No ☐ Yes:____drinks/day

Do you take any other 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_____from _____

Mother ☐ Alive, age_____ ☐ Deceased at age_____from _____

Brothers/Sisters _____

_____

Children _____

_____

OVER

HAVE YOU HAD:

- ☐ Night sweats, ☐ fever, ☐ chills, ☐ loss of appetite, ☐ weakness ☐ recent weight change (☐ loss___lbs, ☐ gain___lbs)
- ☐ Sores, ☐ itching, ☐ rashes, ☐ changes in moles, ☐ skin cancers
- ☐ Fatigue, ☐ excessive sweating, ☐ excessive urination, ☐ excessive thirst, ☐ heat or cold intolerance
- ☐ Blackouts, ☐ vertigo, ☐ headache, ☐ loss of vision, ☐ paralysis, ☐ loss of sensation, ☐ memory loss
- ☐ Blurred or double vision, ☐ diminished vision
- ☐ Excessive/easy bleeding or bruising, ☐ frequent nosebleeds, ☐ swollen glands, ☐ blood clots in your legs
- ☐ Shortness of breath, ☐ cough, ☐ hearing loss, ☐ ringing in ears, ☐ wheezing
- ☐ Chest pain/pressure, ☐ leg pain with walking, ☐ palpitations, ☐ leg swelling
- ☐ Yellow skin or eyes, ☐ nausea, ☐ vomiting, ☐ diarrhea, ☐ constipation, ☐ changes in bowel habits, ☐ blood in bowel movements
- ☐ Joint stiffness, ☐ joint pain, ☐ joint swelling, ☐ back pain, ☐ fractures
- ☐ Depression, ☐ sleep disturbances, ☐ thoughts of suicide, ☐ anxiety, ☐ hallucinations

MALES:

- ☐ Dark urine, ☐ blood in urine, ☐ difficult/painful urination ☐ frequent urination, ☐ difficulty attaining an erection

FEMALES:

- ☐ Dark urine, ☐ blood in urine, ☐ difficult/painful urination ☐ frequent urination, ☐ pelvic pain, ☐ painful menstrual periods, ☐ vaginal discharge

REVIEWED:

Date: _____

_____

_____

_____

_____

Alan C. Mintz, MD
Vascular & Endovascular Surgery
Diplomate, American Board of Surgery
2220 Lynn Road Suite 306
Thousand Oaks, CA 91360
(805)496-9727

Assignment of Benefits

I hereby 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. Alan C. Mintz, 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 hereby authorize said assignee to release all information necessary to secure payment.

Signed:_____Date:_____

Alan C. Mintz, M.D. **Trung D. Bui, M.D.**
Vascular & Endovascular Surgery
2220 Lynn Road, Suite 306
Thousand Oaks, CA 91360
(805) 496-9727

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 has 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

NOTICE OF PRIVACY PRACTICES

Date of Last Revision: 4-29-03
Effective Date: Immediately

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice describes our Practice's policies, which extend to:

- All areas of the Practice (front desk, administration, billing and collection, etc.);
- All employees, staff and other personnel that work for or with our Practice;
- Our business associates (including a billing service, or facilities to which we refer patients), on-call physicians, and so on.

The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION:

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

We are required by law to:

- make sure that the protected health information about you is kept private;
- provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and
- follow the conditions of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or disclosures provides a general explanation and provides some examples of uses. Not every use or disclosure in a category is either listed or actually in place. The explanation is provided for your general information only.

- Medical Treatment. We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore we may, and most likely will, disclose medical information about you to doctors, nurses, technicians or hospital personnel who are involved in taking care of you.
- Payment. We may use and disclose medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example,

we may need to give your health care information, about treatment you received at the Practice, to obtain payment or reimbursement for the care.

- Health Care Operations. We may use and disclose medical information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff. We may also use or disclose information about you for internal or external utilization review and/or quality assurance, to business associates for purposes of helping us to comply with our legal requirements, to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor, at all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your medical records.
- Appointment and Patient Recall Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise and may involve the leaving an e-mail, a message on an answering machines, or otherwise which could (potentially) be received or intercepted by others.
- Emergency Situations. In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.
- Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.
- To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- Public Health Risks. Law or public policy may require us to disclose medical information about you for public health activities.
- Investigation and Government Activities. We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.
- Law Enforcement. We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process.
- Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Practice to funeral directors as necessary to carry out their duties.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, in the top right-hand corner, the date of last revision and effective date. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact Dr. Mintz, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following rights regarding medical information we maintain about you:

- Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

  To inspect and copy your medical record, you must submit your request in writing to our office staff. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that we review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

- Right to Amend. If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your medical record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Practice;

- Is not part of the information which you would be permitted to inspect and copy; or
- Is inaccurate and incomplete.

- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others.

To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before April 14, 2003 (or the actual implementation date of the HIPAA Privacy Regulations). Your request should indicate in what form you want the list (for example, on paper, electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

  We are not required to agree to your request and we may not be able to comply with your request. If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is excepted from the consent requirement or we are otherwise required to disclose the information by law.

  To request restrictions, you must make your request in writing. In your request, you indicate:

  - what information you want to limit;
  - whether you want to limit our use, disclosure or both; and
  - to whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all *reasonable* requests. Your request must specify how or where you wish us to contact you.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.