PATIENT REGISTRATION FORM Dr. Francis Teng 3150 N Tenaya Way #508 702-838-5888

PATIENT INFORMATION:

Last Name:_____ **First Name:**_____ **MI:**_____

Address:_____ **APT:**_____ **City:**_____ **State:**_____ **Zip:**_____

Date of Birth:____/____/____ **Social Security Number:**_____/_____/_____ **ETHNICITY:** White/Asian/Black/Hisp/Pacific Islander

Home Number:_____ **Work Number:**_____ **Text Number:**_____

Employer:_____ **Employer Address:**_____

Marital Status(Circle): Married/Single/Divorced/Widowed **EMAIL ADDRESS:**_____

Referred by (Doctor,Google):_____ ER Contact #:_____ Phone#_____

***I authorize & permit Dr. Teng's office to discuss my care with:** _____ **Relationship:**_____

INSURANCE INFORMATION:

***PRIMARY INSURANCE:**

INSURANCE NAME:_____ PHONE NUMBER:_____

Policy Holder Name:_____ Relationship:_____

***SECONDARY INSURANCE:**

INSURANCE NAME:_____ PHONE NUMBER:_____

Policy Holder Name:_____ Relationship:_____

SIGNATURE REQUIRED:(Please read carefully,sign, and date below.)

*Authorization to release information. I hereby authorize the Provider and their Agents and Assignments to release any information required by my insurance company, another doctor or a hospital, acquired in the course of my examination or treatment.

*Authorization to pay benefits to Provider. I hereby authorize my insurance benefits to be paid directly to the Provider and I am responsible for non-covered services. I understand that my insurance policy is a contract between my insurance company and myself and that I am responsible to Dr. Teng any fees not covered by insurance.

* I acknowledge and agree that I am responsible for payment of all services rendered and charges incurred by me. I also understand that the Provider will bill my insurance as a courtesy to me. If payment is not received within 90 days from the date of billing, I understand and acknowledge that I must immediately make full payment, including interest, to the Provider .

* I acknowledge and agree that payment is due when services are rendered and that a service charge in the amount of 1.75% per month will accrue on all unpaid balances which remain unpaid for 30 days after services are rendered. I also agree to pay all costs of collection including actual attorneys' fees to collect any unpaid balances. In addition, if any legal proceeding or any action is brought to enforce this agreement or arising out of this agreement, I agree that the prevailing party is entitled to reimbursement of actual costs and attorneys' fees incurred therein. Further, I authorize Advance Surgical Care, and its agents and assigns, to investigate any data obtained from any person pertaining to my credit worthiness or financial responsibility. The Provider and their Agents are authorized to check my credit history at their discretion.

*I consent to any medical treatment deemed medically necessary by the provider. I understand that these treatments will be discussed with me and all questions answered before rendered.

*If patient is a minor, then parent or guardian agrees to be responsible for payment in full for services rendered.

**_____ I understand that I will be charged $25 dollar fee for an unexcused no-show/cancellation within 24 hours of my appointment time.

**_____I also agree to pay a $25 dollar fee for any returned checks

Signature:_____ Date:_____

ADVANCED SURGICAL CARE
FRANCIS W. TENG, M.D.
PATIENT RECORD

Today's Date:_____

Last Name:_____First:_____MI:_____

Date of Birth:__/____/____Sex:_____

Reason for your visit today:_____

Have you ever had any of the following?	YES	NO		YES	NO
High blood pressure?			Ulcers?		
Chest pain/angina?			Colitis/bowel disease?		
Heart attack?			Change in bowel habits?		
Palpitations, irregular or fast heart beat?			Dark or bloody stools?		
Blood disease/bleeding problems?			Back pain/injury?		
Asthma?			Stroke?		
Tuberculosis?			Seizures?		
Pneumonia?			Diabetes/High blood sugar?		
Emphysema?			Thyroid Disease?		
Shortness of breath?					

Are you taking the following medications?	YES	NO	If yes, please give name and dosage of medication.
Steroids?			
Aspirin?			
Blood thinners/coumadin?			
Blood pressure medication?			
Heart medication?			
Insulin?			
Diuretics?			
Other?			

Have you ever had a reaction to any type of medication? If so, please name the medication and explain reaction.

_____

_____

Have you ever had surgery? If so, please list below:

Type of Surgery	Date	Surgeon

Tobacco use: Smoker?_____Packs per day?_____Year started smoking?_____Date quit:_____

Alcohol use: How much per day?_____

Use of street drugs (past or present)?_____

Have you ever been diagnosed with Hepatitis?_____

Have you ever been diagnosed with HIV?_____

Have you ever received a blood transfusion?_____

Advanced
Surgical
Care

FRANCIS W. TENG, M.D., F.A.C.S.

Diplomate American Board of Surgery
Specializing in General, Laparoscopic, & Bariatric Surgery
3150 N. Tenaya, Suite 680 • Las Vegas, NV 89128
(702) 838-5888 • Fax (702) 838-4251

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained.

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (please provide specific details)

_____

_____

_____

_____ _____

Employee signature Date

MEDICAL RECORDS RELEASE

Specify Date or Time Period for Information Selected above:

Notice: Advanced Surgical Care and many other organizations and individuals such as physicians, hospitals, and health plans or required by law to keep your health information confidential. If you have authorized the disclosure of our health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

My Rights:

- I understand I may refuse to sign this authorization to release protected health information. I understand that my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.

- I may revoke this authorization at any time, provided that I do so in writing and submit to Advanced Surgical Care, 3150 N. Tenaya Way, Suite #680, Las Vegas, NV 89128. The revocation will take effect when our office receives it, except to the extend that our office or others have already relied on it.

- I am entitled to receive a copy of this Authorization.

Expiration of Authorization:

Unless otherwise revoked, this authorization expires _____. If no date is indicated, this authorization will expire 12 months after the date of signing this form.

SIGNATURE:

_____ _____

(Signature of Patient or Legal Representative) Date

_____ _____AM/PM

Printed Name Time

_____

(If signed by someone other than the patient, state your legal relationship to the patient/authority)

_____

Witness or Translator

FRANCIS W.TENG, M.D., F.A.C.S

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NO SHOW POLICY

(MISSING APPOINTMENTS OR SCHEDULED SURGERIES)

Unfortunately we have found it necessary to charge for Missed Appointments (ex: not keeping appointments scheduled with our office). Patients that DO NOT show up (or present for appointments and are not able to pay the insurance copays) for their scheduled appointments are preventing us from scheduling other patients with urgent needs.

As a courtesy, we will confirm your appointment prior to its scheduled date, however, the final responsibility will rest with the patient. Effective January 1, 2016, there will be a charge of $25 for each missed appointment.

A missed appointment is defined as:

*Not showing to a scheduled appointment
*Cancellation or rescheduling without a 24 hour notice (during business hours)
*Presenting to appointment, but not able to pay for Office Visit
*Two (2) "no shows" constitute dismissal

A missed surgery appointment without prior notice (48 hours) may lead to unnecessary delay in care caused by the patient and can impact outcomes. Any missed surgery appointments will constitute a $50 charge. It will be at the discretion of the surgeon whether or not the delay merits dismissal from our practice. We will NOT assume responsibility for the patient's self-imposed (by missed scheduled appointments) delay in care.

You must cancel by direct phone call to the office (702-838-5888) or email your cancellation to tina@lvlapband.com 24 hours, prior to your scheduled appointment. This is to mean if your appointment is Monday, then you must cancel your appointment by Friday before the scheduled appointment.

Patient/Guardian signature:_____ Date: _____

VEIN SCREENING FORM
Please complete left side of form only.

Date: _____ Appt Time: _____ Screening Provider: _____

Name: _____ Primary Care Physician: _____

Phone: _____ Insurance Provider: _____

Email: _____

DOB: _____ Sex: ☐M ☐F

I. Vascular History

Do you have or have you ever been diagnosed with:

Varicose vein problems	☐Y ☐N	Leg: ☐R ☐L
Phlebitis (vein redness/tenderness)	☐Y ☐N	Leg: ☐R ☐L
Blood clots	☐Y ☐N	Leg: ☐R ☐L
Deep vein thrombosis (DVT)	☐Y ☐N	Leg: ☐R ☐L
Saphenous vein reflux	☐Y ☐N	Leg: ☐R ☐L

Do you experience any of the following in your leg(s):

Aching/pain	☐Y ☐N	Leg: ☐R ☐L
Heaviness	☐Y ☐N	Leg: ☐R ☐L
Tiredness/fatigue	☐Y ☐N	Leg: ☐R ☐L
Itching/burning	☐Y ☐N	Leg: ☐R ☐L
Swelling	☐Y ☐N	Leg: ☐R ☐L
Cramps	☐Y ☐N	Leg: ☐R ☐L
Restless legs	☐Y ☐N	Leg: ☐R ☐L
Throbbing	☐Y ☐N	Leg: ☐R ☐L
Skin or ulcer problems	☐Y ☐N	Leg: ☐R ☐L
Other:	☐Y ☐N	Leg: ☐R ☐L

Which of the following do you currently do to improve your leg vein symptoms:

Medication for pain	☐Y ☐N	What? _____
Elevation of legs	☐Y ☐N	What? _____
Wear support hose	☐Y ☐N	What? _____

II. Family History

Have any of your family members had:

Varicose veins	☐Y ☐N	Who? _____
Vein stripping	☐Y ☐N	Who? _____
Blood coagulation disorder	☐Y ☐N	Who? _____
Blood clots	☐Y ☐N	Who? _____
Stroke, heart attacks or pulmonary emboli	☐Y ☐N	Who? _____

III. Vein Treatment History

Have you ever been treated for varicose veins with:

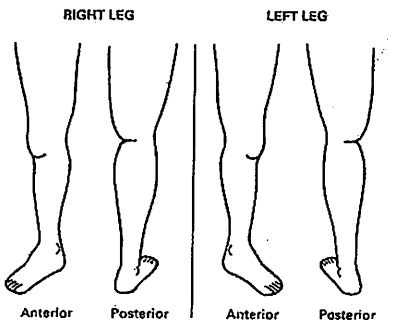
Sclerotherapy	☐Y ☐N	Leg: ☐R ☐L
Laser therapy (spider veins)	☐Y ☐N	Leg: ☐R ☐L
Phlebectomy	☐Y ☐N	Leg: ☐R ☐L
Vein stripping surgery	☐Y ☐N	Leg: ☐R ☐L
RF ablation (VNUS Closure®)	☐Y ☐N	Leg: ☐R ☐L

IV. Personal Activities List

Does your work require:

Prolonged standing periods	☐Y ☐N	
Prolonged sitting periods	☐Y ☐N	
Do you exercise regularly?	☐Y ☐N	
Do you smoke?	☐Y ☐N	
Pregnancies	☐Y ☐N	How many? ___

V. Vein Screening (to be completed by screening provider)



Physical Exam:

CEAP Clinical Signs:

RIGHT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

LEFT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

Clinical Assessment:

☐ Chronic venous insufficiency ☐R ☐L
☐ Other: _____ ☐R ☐L

Treatment Plan:

☐ Duplex ultrasound ☐R ☐L
☐ Sclerotherapy ☐R ☐L
☐ Medical compression stockings ☐R ☐L
☐ Other: _____ ☐R ☐L

Screening Provider Signature: _____

Follow-Up Appointment

Date: _____ Time: _____

Physician: _____

Physician Phone Number: _____

NOTES:

****EVALUATE FOR **BLOOD CLOTS** AND **VASCULAR DISEASE*****