MAB
MEDICAL ASSOCIATES OF BREVARD

Dr. Peter Dovgan M.D., FACS
655 S. Apollo Blvd
Melbourne, FL 32901

Phone :(321)751-2707
Fax: (321) 255-2361

Space Coast Vascular

HISTORY OF PRESENT ILLNESS

- Patient Name:_____
- Patient Birth Date: _____ • Today's Date: _____
- Reason for today's visit: _____
  - -Have you had any Labs, Ultrasounds, X-rays, MRI's, CT's, etc.? YES NO
  - -If yes, explain which:_____
- In case of a surgical emergency, are you willing to receive blood or blood products? YES NO
- Are you pregnant, nursing or planning a pregnancy in the near future? YES NO

Primary Care Physician: Dr._____ Referring Physician: Dr._____

Cardiologist Physician: Dr._____ Nephrology Physician: Dr. _____

Endocrinology Physician: Dr._____Podiatry Physician: Dr._____

Pain Management Physician: Dr._____ Other Physician:_____

PAST MEDICAL HISTORY

Please provide dates and results for the following:
Date of most recent cardiac stress test _____Passed? YES NO

Date of most recent heart catheterization _____Stents? YES NO

Do you smoke? **YES** ____# Packs/ Day **NO** Date Quit _____

Do you drink alcohol? **YES** Qty/ Frequency: _____per week **NO** Date Quit _____

Allergies: _____

Past Surgeries: ___None ___Carotid ___Aneurysm ___Vascular Bypass ___Hernia ___Hysterectomy

___Tonsils ___Appendix ___Gallbladder other:_____

Do you have problems/ complications with anesthesia? YES NO

Have you had any Falls in the past year? ___Yes ___No Two or more Falls with injury? ___Yes ___No

MEDICATIONS

Name	Dosage	How Often

Patient Name:_____Patient D.O.B: _____

Have you had any of the following?

✓	DISEASE	COMMENTS
	Seizure Disease?	How often?_____
	Thyroid Disease	____ Hypothyroidism ____ Hyperthyroidism ____ Goiter ____
	Pulmonary Disease	____ Asthma ____ COPD ____ Emphysema ____ TB ____ Pneumonia
	Stroke	___TIA (mini stroke) ___Sudden blindness ___Weakness in arms/legs ____ Carotid stenosis _____ Bruit
	GI Disease	_____ Ulcers ____Hiatal Hernia ___GERD _____Diverticulitis _____Crohn's ____Gallstones
	Diabetes	____Insulin dependent ___Non-insulin ___Controlled by diet
	Kidney Disease	___ESRD ____Dialysis
	Blood Disease	____Bleeding Disorder ____Clotting Disorder
	Liver Disease	____Hepatitis ___Cirrhosis
	Cancer	____Type:
	Vascular Disease	__Peripheral Vascular Disease ___ Angioplasty/Stent __ Leg/Foot Ulceration __ Claudication ___Decreased walking distance ___Foot pain at rest __ Foot pain during exercise __ Extreme discoloration changes __ Loss of limb ___ Aneurysm ___Diabetic neuropathy ____ Temperature changes
	Heart Disease	__ Heart Attack/ MI ___ Angina __Hypertension ___ CHF __Coronary angioplasty/stent/PTCA ___Open heart surgery/CABG __ AFIB ____ IRRG HR ___ Murmur ___Rheumatic heart disease __ Valve disease/repair/replacement ___Coronary heart disease

FAMILY HISTORY

Please check the boxes pertaining to your family history.

	FATHER	MOTHER	BROTHERS	SISTERS
Living				
Deceased Cause/death				
Age of death				
Cancer				
Diabetes				
Heart Attack				
Stroke				
PVD				
COPD				
TB				
Other Problems:				

MAB
MEDICAL ASSOCIATES OF BREVARD

Dr. Peter Dovgan M.D., FACS
655 S. Apollo Blvd
Melbourne, FL 32901

Phone : (321)751-2707
Fax: {321)255-2361

Space Coast Vascular

VENOUS HISTORY

Today's Date:_____ Patient DOB:_____

Patient Name:_____

Are you pregnant, nursing or planning a pregnancy in the near future? Yes No

Check box in front of ALL that apply:

SYMPTOMS:

	Aches		Heavy/full feeling		Symptoms interfere w/ activities of daily living
	Easy Bruising		Bleed/ Hemorrhage		Leg Restlessness
	Swelling		Cramping		Pelvic Symptoms
	Muscle fatigue		Itch		Ulceration___Healed ___Non-healed, How long present?____
	Pain		Burning		I am NOT able to walk a mile without symptoms

WORSE WHEN:

	Standing		Sitting		Walking/exercise
	Pre-menstrual		Night time		Other:
	Worsening of symptoms with pregnancy; Date of last pregnancy:_____				

CONSERVATIVE THERAPY:

	Leg Elevation		Elastic compression garment use; Attempted more than 3-6 months.
	Exercise		Compression garment use Helpful
	Heat		Compression garment use Failure; Reason:_____
	Medications: _____		Other:_____

PREVIOUS INVASIVE TREATMENT:

	SURGERY:		Stripped-right leg		Stripped-left leg	Date:	Complications?	Y N
	SURGERY:		Ligation-right leg		Ligation-left leg	Date:	Complications?	Y N
	INJECTIONS:		Right leg		Left leg	Date:	Complications?	Y N
	LASER:		Right leg		Left leg	Date:	Complications?	Y N

COMMENTS:

_____

_____

_____

_____

Patient signature: _____ Date_____

Dr. Peter Dovgan M.D., FACS
655 S. Apollo Blvd.
Melbourne, FL 32901

Phone:(321)751-2707
Fax: (321)255-2361

CANCELLATION POLICY

OFFICE VISITS, VASCULAR LAB TESTS, SURGICAL PROCEDURES

To better serve all of our patients, it is extremely important that when you schedule your visits, *tests*, or surgical procedures that you have thoroughly checked your personal calendar to make sure the time is ideal for you. Cancelling and rescheduling causes other patients to wait longer and delay treatment times.

UNPLANNED CANCELLATIONS AND NO SHOW POLICY

- Each *Office visit* will be rescheduled one time as a courtesy. After that time, a **$50 fee** will be charged to your personal account and not billed to insurance for every cancellation less than **24 hours of** the scheduled appointment or a No Show appointment.
- Each *Vascular lab test* will be rescheduled one time as a courtesy. After that time, a **$150 fee** will be charged to your personal account and not billed to insurance for every cancellation less than **24 hours** of the scheduled appointment or a No Show appointment.
- *Surgical procedures in the office* must be cancelled or rescheduled **48 hours** in advance. Failure to do so will result in a **$200 fee** charged to your personal account and not billed to insurance.
- *Surgical procedures in the Hospital* cannot be rescheduled. If you must cancel, it will need to be within 72 hours to release the time to other hospital patients. Failure to do so, will result in a **$250 fee** charged to your personal account and not billed to insurance.

- After 3 cancellations with late notices or 3 No Show appointments, the patient will be required to speak with the Practice Administrator before rescheduling.

Thank you, Space Coast Vascular Staff

I have read, understand and agree to the cancellation, no show and financial policies of Space Coast Vascular.

Patient Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

New Patient Registration

MEDICAL ASSOCIATES OF BREVARD

Patient Information

Patient Name

_____

First MI Last

DOB ___/___/_____ SS# _____

Marital Status_____ ◯ MALE ◯ FEMALE

Address _____

_____

Home Phone _____ Cell _____

Work Phone _____

Employer _____

Occupation _____

Name of Spouse _____

Address: _____

_____

◯ Check if same as patient's address

Race

◯ American Indian or Alaska Native ◯ Asian
◯ Native Hawaiian ◯ Black or African American ◯ White
◯ Other Pacific Islander ◯ Prefer not to answer

Ethnicity

◯ Hispanic/Latino ◯ Non-Hispanic/Latino
◯ Prefer not to answer

Preferred Language

◯ English ◯ Spanish ◯ French ◯ Indian (includes Hindu & Tamil) ◯ Other _____

Preferred Pharmacy _____

Location _____

Family Doctor _____

Phone _____

Insurance Information

Primary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Secondary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Complete below if patient is a minor

Father's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

◯ Check if same as patient's address

Employer _____

Mother's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

◯ Check if same as patient's address

Employer _____

MAB
MEDICAL ASSOCIATES OF BREVARD

New Patient Registration

HIPAA Release

Patient Name

First MI Last

Do you have a Living Will? ◯ Yes ◯ No
Do you have an Advance Directive? ◯ Yes ◯ No
If you answered yes to either, please provide us a copy.

Emergency Contact:

Name Relationship

Phone #

I authorize Medical Associates of Brevard LLC to discuss my healthcare information with the below:

Name Relationship

Phone #

Name Relationship

Phone #

Preferred appointment reminder notification:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Preferred medical information notification:
I authorize Medical Associates of Brevard LLC to leave a detailed message which may contain personal health information via:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.

Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.