Stephen J. Hopkins, MD, FACS

Today's Date:	Primary Care Provider / Physician:

PATIENT/SPOUSE INFORMATION

Patient's Last Name: First: Middle:	Sex: ☐ M ☐ F	☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐ Dr.	Marital Status (circle one) Sing / Mar / Div / Sep / Wid

Preferred Method of Contact:	Home Phone No.:	Work Phone No.:	Cell Phone No.:

Preferred E-mail Address:

Billing Address:	City:	State:	Zip:
Physical Address (if different):	City:	State:	Zip:

Occupation:	Name & Address of Employer:	Date of Birth:
How did you hear about us?		

Spouse's Name:	Spouses Employer:	Spouses DOB:	Spouses Work Phone No.:	Spouses Cell No.:

INSURANCE/ACCOUNT INFORMATION

Person Responsible for Account:	Address (if different):	Home Phone No.:

Preferred e-mail address of person responsible for account:

Name of Primary Insurance: ☐ Medicare ☐ Blue Cross ☐ Blue Shield ☐ Other:

Primary Ins. Subscriber's Name:	Birth Date:	Policy No.:	Group No.:

Patient's Relationship to Primary Insurance Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of Secondary Insurance:	Subscriber's Name:	Policy No.:	Group No.

Patient's Relationship to Secondary Insurance Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

IN CASE OF EMERGENCY

Name of Local Friend or Relative:	Relationship to Patient:	Home phone No.:	Work phone No:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Stephen J. Hopkins, MD. I understand that I am financially responsible for any remaining balance not covered by my insurance. I also authorize Stephen J. Hopkins, MD to release any information required to process my claims. A $55.00 fee will be added to your account if it is sent to collections. A monthly interest of 1.5% will be charged on any balance over 90 days after service. Thank you for your trust and confidence. We look forward to caring for you.

Patient/Guardian Signature:	Date:

Medical and Surgical Patient History Information

Name:	Date Form Completed:	Date of Birth:	Age:
Why are you here to us today?	Who is your Primary Provider?	Who Referred you?	

Medical History: (If you HAVE, OR HAVE HAD any of the following below)
(Fill in the Date it started, to the best of your knowledge)

Medical Condition	Date Started	Medical Condition	Date Started
Anemia		Hepatitis	
Pneumonia		Hernias (Type)	
Emphysema		Diabetes	
Chronic Obstructive Pulmonary Disease		Varicose Veins or Venous Reflux Disease	
Asthma		Arthritis (Type: Osteoarthritis or Rheumatoid)	
Hyperthyroidism/Hypothyroidism		Gastroesophageal Reflux Disease	
Hypertension		Ulcerative Colitis or Crohn's Disease	
Heart Attack or Stroke		**List All Other Medical Problems Below:**	
Heart Disease (Type):		1	
Elevated Cholesterol		2	
Peptic Ulcer Disease		3	
Traumatic Injury (Type):		4	
Gallbladder Problems		5	
Cancer (Type):		6	
Headaches (Type:)		7	

List Any Additional Medical Conditions Below:

Surgical History:

Surgical Procedures	Date of Procedure	Surgical Procedures	Date of Procedure
Hernia (type):		Breast (Type):	
Lung (Type):		Plastic (Type):	
Kidney (Type):		Pediatric (Type):	
Thyroidectomy (Type):		Heart (Type):	
Tubal Ligation		Appendectomy	
Trauma (Type):		Artery Surgery (Type):	
		Varicose Vein (Type):	
Vasectomy		Small Bowel (Type):	
Cancer (Type):		Colon (Type):	
Skin Cancer (Location):		Hysterectomy	
Tonsillectomy		**List All Other Surgical Procedures Below:**	
Orthopedic (Type):		1	
Laparoscopic (Type):		2	
Gallbladder Removal (Open / Laparoscopic)		3	
Eye (Type):		4	

Social and Family History:

Do you smoke? Yes / No	Have you ever smoked? Yes / No	If you have smoked or still smoke, how many packs per day, and for how many years? Packs per day _____ # of Years _____	If you quit, when did you quit (year)?
Do you drink alcohol? Yes / No	Have you ever drank alcohol? Yes / No	How many drinks? What type of drink? How frequent (drinks per day/week/month/year). For how many years?: **How Many:** **Type of Drink:** **Frequency:** **Years:**	
Please list any <u>immediate</u> family illnesses: (Mother, Father, Siblings, Children)			

List All Allergies to Medications:

Medication:	**What type of reaction did you have with this medication? (Hives, Rash, Anaphyaxis)**

Please List All Medications That You Take: (Important !!!)

(If you are at all unsure of your medications, **bring in all your bottles and/or get a current list from your primary provider or pharmacist**. Please do this before your appointment in our office - this is very important so that we can remain compliant with government-mandated electronic medical record requirements and for your health to **prevent medication errors**)

MEDICATION	AMOUNT? (MILLIGRAMS, UNITS, PUFFS)	HOW IS THIS GIVEN? (BY MOUTH, INJECTION, PATCH, OR PUFF INHALATION)	HOW MANY TIMES A DAY DO YOU TAKE THIS MEDICATION?
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Review of Systems History:

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?	YES	NO	IF YES, GIVE AS MUCH DETAIL AS POSSIBLE
Constitutional			
Fever, chills, night sweats?			
Fatigue or weakness?			
Recent weight gain or loss?			
Eyes			
Blurry vision, tearing, itching or visual loss?			
Visual appearance of a "window shade" coming down over your eye?			
Ears, Nose, Mouth and Throat			
Ringing in the ears or loss of vision?			
Nosebleeds or loss of smell?			
Nasal drainage or nasal stuffiness?			
Post nasal drip or sore tongue?			
Bleeding gums or sore mouth?			
Loss of sense of taste or dry mouth?			
Frequent sore throat, hoarseness, difficulty with swallowing or painful swallowing?			
Cardiovascular			
Chest pain or shortness of breath?			
Irregular or sudden change in heart beats palpitations or history of murmur			
Respiratory			
Cough, difficulty breathing, or coughing blood?			

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?	YES	NO	IF YES, GIVE AS MUCH DETAIL AS POSSIBLE
Sleep apnea, oxygen use, or CPAP use?			
Sleep with extra pillows?			
Vascular			
Muscle pain of your legs when you walk which is relieved with rest?			
Pain and/or aching in your legs, worsened by prolonged standing or sitting and relieved with elevation or compression stockings?			
Spider veins?			
Varicose veins?			
Leg, feet or ankle swelling?			
Leg ulcers or abnormal skin changes in your legs?			
History of blood clots?			
Gastrointestinal			
Decreased appetite?			
Nausea or vomiting?			
Upper abdominal pain? Right or Left?			
Lower abdominal pain? Right or Left?			
Heartburn?			
Diarrhea?			
Constipation?			
Jaundice or gas pain?			
Narrow stools?			
Blood in the stools?			
Dark or black (tarry) stools?			

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?	YES	NO	IF YES, GIVE AS MUCH DETAIL AS POSSIBLE
Red rectal bleeding, rectal pain with bowel movements, or hemorrhoids?			
Genitourinary			
Difficulty or pain with urination?			
Frequent urination during the day or at night?			
History of kidney stones?			
Blood in the urine?			
Sexual difficulties?			
History of sexually transmitted diseases?			
Musculoskeletal			
Arm, buttock, thigh or calf cramps?			
Joint or muscle pain?			
Weakness or tenderness?			
Neck pain?			
Back pain?			
Joint swelling?			
Bone or Joint Injuries?			
Integumentary System			
History of breast mass?			
Abnormal skin lesions that have recently changed?			
Areas of itching or rashes?			
Neurological System			
Loss of sensation or numbness?			
Tremors, weakness or paralysis?			

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?	YES	NO	IF YES, GIVE AS MUCH DETAIL AS POSSIBLE
Fainting, blackouts, or seizures?			
Difficulty Speaking?			
Psychiatric			
Changes in mood?			
Anxiety or depression?			
Memory problems?			
Alcohol or drug abuse problem?			
Endocrine System			
Fatigue or Irritability?			
Hyperthyroidism or hypothyroidism?			
Excessive eating or drinking?			
Excessive urination?			
Trouble tolerating heat or cold?			
Hematologic and Lymphatic System			
Easy bruising/bleeding?			
Transfusions or blood clots?			
Genetic condition that increases risk of either blood clotting or bleeding?			
Lymph node swelling or lymphedema?			
Allergic and Immunologic System			
Autoimmune disease or food allergy?			

List Anything Else We May Need to Know About Your Health History Below:

To the best of my knowledge, the above information is correct: _____

(Signature of Patient)

MOTHER LODE VEIN INSTITUTE
STEPHEN J. HOPKINS, MD, MS, FACS

Sonora Office: 680 Guzzi Lane, Suite 103 · Sonora, CA 95370
209-532-5528 · FAX 209-532-5598
Jackson Office: 815 Court Street, Suite #4 · Jackson, CA 95642
209-256-8081 · FAX 209-532-5598
MotherLodeVeinInstitute.com
Board Certified in Phlebology · Board Certified in General Surgery

Cancellation Policy

All of our patients are important to us, and we want to be respectful of their time waiting in our office, therefore, we do not overbook or 'double-book' our patients. It can be very costly to have multiple late cancellations or 'No-Shows' that leave us very little time to fill that vacant appointment time. In order to serve our patients better, we have instituted a cancellation policy. If you cannot keep your appointment, please contact us 72 hours in advance to cancel your appointment. If you do not cancel 72 hours in advance, you will be charged a late cancellation or 'No- Show' fee of $50 for Office Consultations. If you must reschedule your appointment, we will only reschedule once.

I have received and read a copy of this cancellation policy. I understand that I must give 72 hours advanced notice if I need to cancel my appointment, otherwise I will be charged a cancellation fee of $50 for Office Visits. I understand that I will not be able to reschedule more than once.

_____ _____

Patient Signature Date

_____

Patient Name (Printed)

Acknowledgement of Receipt Notice of Privacy Practices

Appointment Date: _____at _____AM/PM

Mon Tues Wed Thurs Fri

If unable to keep this appointment, please notify our office
(209)-532-5528 or (209)-256-8081 or
MotherLodeVeininstitute.com

To Our Patients,

The Privacy of your health care information is extremely important to us. We want you to understand how we use and disclose your information and your rights to this information. We ask you ask you to review our Notice of Privacy Practices that describes our legal duties with respect to your health care information.

How we use health care information:

We use information about you to:

- ✓ Provide treatment to you
- ✓ Ensure appropriate payment for the treatment we provide, and
- ✓ Monitor the quality of our operations.

When we may disclose information:

In certain limited cases we are permitted to disclose care information about you. Examples include when there is a serious threat to health or safety, for worker's compensation, to reduce public health risks, for health oversights and in certain cases for law enforcement. In addition, we may disclose information to tell you about health-related services and alternative treatments, and to conduct health-related research with your permission.

Your Information Rights:

We create a record of the care we give you.

✓ You have the right to know how we use your health information, who we can give it to, and your rights to this information. (Please see our Notice of Privacy Practices)
✓ You have the right to ask us to restrict uses and disclosures where we believe such restrictions will not harm you and where it is possible for us to do so.
✓ You have the right to confidential communication of your health information. For example, you can ask for conversation to be held in private or for us to send a copy of your bill to a different address.
✓ You have the right to look at and get a copy of information in our record unless your doctor has indicated this would be harmful to you or someone else.
✓ You have the right to request that our records be amended if we agree it is inaccurate or incomplete.
✓ You have a right to ask for a list when we have disclosed your health information to someone other than those treating you, handling your bills, for our internal operations, or when you have authorized release of information.

Please sign below that you have received our Notice of Privacy Practices. If you have any question, please speak to your physician or our office manager.

Signature: _____ Date: _____

Print Name: _____ SSN: _____-_____-_____