UT Physicians
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SHEILA COOGAN, MD, FACS

UT CV Surgery
Vascular Specialist

GENERAL INFORMATION

Name: _____ Date of Birth: _____/_____/_____ Age: _____

Social Security #: _____/_____/_____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D

Address: _____ City: _____ Zip: _____

Home #: _____ Cell #: _____ Work #:_____

Email: _____ Work Status: ☐ Retired ☐ Disabled ☐Un-employed ☐ Employed

Occupation: *(if employed)* _____ Employer: _____

Name of Emergency Contact: _____ Phone #: _____

OTHER INFORMATION

How were you referred to Dr. Coogan? ☐ Physician ☐ Insurance ☐ Internet ☐ Friend/Family

Referring Physician *(if applicable):* _____ Office #: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare and/or Medicaid to issue payment check(s) directly to UT Physicians for medical services rendered to myself and/or my dependents. I hereby consent to all necessary medical treatment as directed per UT Physicians. I understand that I am responsible for any co-pay or deductible due at the time of service, as well as any balance owed in the event that my insurance company did not cover a particular service.

_____ _____

Patient's Signature ***Date***

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Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

- I authorize the release and/or disclosure of all requested healthcare information to be mailed and/or faxed to:

  Sheila M. Coogan, MD, FACS
  6700 West Loop South, Suite 110
  Bellaire, TX 77401
  713.486.5200 / 713.664.7929 fax

- This authorization applies to:

  ☐ All healthcare information
  ☐ Demographics
  ☐ Clinic Notes
  ☐ Lab Reports
  ☐ Imaging Reports/Images/photographs
  ☐ Other (please specify) _____

> ***Note**: If records contain any information regarding HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

- Please release healthcare information provided on the following date(s): _____

- This authorization shall expire no later than one full calendar year from the below signature date unless otherwise stated.

- I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Patient's Signature _____ ***Date*** _____

Witness _____ ***Date*** _____

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Medical History Form

Patient Name: _____ Date of Birth: _____/_____/_____

- Primary Care Physician: _____Office #: _____
- Cardiologist: _____Office #: _____
- Nephrologist: _____ Office #: _____

Are you currently on dialysis? ☐No ☐Yes *(please complete the information below)*

Dialysis center name: _____ Office #: _____

Dialysis center address: _____

PATIENT HISTORY

☐Abdominal Aneurysm	☐Thoracic Aneurysm	☐Popliteal Aneurysm	☐Varicose Veins
☐Bleeding Disorder	☐Carotid Stenosis	☐Heart Failure	☐Heart Attack
☐End Stage Renal Failure	☐Diabetes	☐Poor Circulation	☐DVT (blood clot)
☐Hepatitis *type*_____	☐High Cholesterol	☐High Blood Pressure	☐HIV/AIDS
☐Chronic Kidney Disease	☐Peripheral Vascular Disease	☐Arterial Stent/Graft	☐Breathing Disorders

FAMILY HISTORY

If yes, please list who under the diagnosis:

☐Anemia ☐Aneurysm ☐Blood Clots ☐Coronary artery disease

_____ _____ _____ _____

☐Diabetes ☐Heart attack ☐Peripheral vascular disease ☐Stroke

_____ _____ _____ _____

☐Varicose veins ☐Other: _____

_____

SURGERIES

- Have you ever experienced a "bad reaction" from anesthesia before? ☐No ☐Yes *(please explain)*

  _____

- Please list all surgeries within the past five years:

  Date _____ Procedure _____

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Date _____ Procedure _____

Date _____ Procedure _____

SOCIAL HISTORY

➢Do you smoke? ☐No ☐Quit ***when?*** _____ ☐Yes ***packs daily?*** _____ ***Year began?*** _____

➢Do you drink alcohol? ☐No ☐Moderate (*social drinking*) ☐Daily

ALLERGIES

➢Do you have any medication allergies: ☐No ☐Yes

➢Do you have any non-medication allergies: ☐No ☐Yes

List all allergies *(if applicable)*: _____ _____

_____ _____

Patient Name: _____ Date of Birth: _____/_____/_____

MEDICATIONS

➢Do you currently take Warfarin/Coumadin or Pradaxa? ☐No ☐Yes

➢Please list all prescription medications below:

☐ **List Attached**

Name of Medicine:	***Dosage:*** *(mg, mcg, ml)*	***Frequency:*** *(How Often)*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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