PENNSYLVANIA VASCULAR ASSOCIATES

SOCIETY HILL VEIN CENTER

PATIENT INFORMATION

NAME:_____Date:_____

DATE OF BIRTH: _____ AGE:_____ HEIGHT: _____ WEIGHT: _____

@EMAIL ADDRESS:_____

SOCIAL SECURITY #:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE #:_____ CELL #: _____

PATIENTS EMPLOYER:_____WORK #:_____

MARITAL STATUS: Single_____Married_____Widowed_____Seperated_____Divorced_____

SPOUSE'S NAME:_____ DATE OF BIRTH:_____

WHERE DID YOU HEAR ABOUT US?_____

WHAT DOCTOR REFERRED YOU TO OUR PRACTICE:_____

REFFERING DOCTOR ADDRESS:_____

PHONE NUMBER #:_____ FAX#:_____

PRIMARY DOCTOR:_____

PRIMARY DOCTOR ADDRESS:_____

PHONE NUMBER#:_____ FAX#:_____

EMERGENCY CONTACT:_____

RELATIONSHIP:_____ PHONE #:_____

INSURANCE INFORMATION
(PLEASE PRINT)

NAME OF **PRIMARY** INSURANCE_____

ADDRESS_____

NAME OF SUBSCRIBER_____ RELATIONSHIP TO SUBSCRIBER_____

POLICY NUMBER_____GROUP NUMBER_____

NAME OF **SECONDARY** INSURANCE_____

ADDRESS_____

NAME OF SUBSCRIBER_____ RELATIONSHIP TO SUBSCRIBER_____

POLICY NUMBER_____GROUP NUMBER_____

FOR PATIENTS WITH MEDICARE COVERAGE PLEASE READ AND SIGN

I request payment of authorized Medicare benefits be made on my behalf to Pennsylvania Vascular Associates, P.C., or for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Agency and its agents any information nedded to determine the benefits payable for related services.

Signature_____**Date**_____

I also request that payment of authorized Medigap benefits be made on my behalf to Pennsylvania Vascular Associates, P.C. for any services furnished me by that physician. I authorize any holder of medical information about me to release to my Medigap insurer any information nedded to determine these benefits payable for related services

Signature_____**Date**_____

FOR PATIENTS WITH COMERCIAL/ANY OTHER INSURANCE PLEASE READ AND SIGN

To process my medical claims for payment I herby authorize Pennsylvania Vascular associated, P.C. or his authorized agents, to release copies of my medical records and/or provide information regarding my Physical or mental condition and treatment rendered to my insurance carrier and/or agent acting on the insurance carrier's behalf. I understand that these records and/or information may include psychiatric/psychotherapy, mental health, drug and/or alcohol information or treatment records, and I authorize the release of such records and/or information to my insurance carrier and/or agent acting on the insurance carrier's behalf.

I hereby assign Pennsylvania Vascular Associates, P.C. all payment for medical services rendered to myself and/or my dependents, and I understand and agree that any services not covered by my insurance company are my responsibility to pay.

Signature_____**Date**_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize the Pennsylvania Vascular Associates to furnish my primary care physician, referring physician, or other treating medical professional any and all information that may be requested regarding my physical or mental condition and treatment rendered there for and, if necessary, to allow them or any physician appointed by them to examine any imaging studies taken of me or records regarding my physical and mental condition or treatment. In addition I also authorize the release of psychiatric/psychotherapy records, mental health records and drug and/or alcohol treatment records under the same terms and conditions. This authorization shall remain in force until revoked in writing by the undersigned.

Signature_____**Date**_____

CONFIDENTIALITY

In addition to release of information as authorized in the AUTHORIZATION TO RELEASE MEDICAL RECORDS, and in the interest of confidentiality, and compliance with HIPAA (Health Insurance Portability and Accountability Act), your careful consideration and acknowledgement as to whom we may release information to on your behalf is required. This would pertain specifically to personal relations, i.e. family, friends, etc. . .

I authorize the release of information (health and demographics) as it pertains to my care only to the following. You may contact our office at any time should you wish to make changes to this authorization.

Name_____Relationship_____Date_____

Name_____Relationship_____Date_____

Name_____Relationship_____Date_____

Signature_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (PRIVACY NOTICE ATTACHED)

I Have been presented with the Pennsylvania Vascular Associates Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction (if any) concerning the use of my personal information.

_____

_____

_____

Signature_____**Date**_____

If not signed by patient, please indicate relationship to patient:

Relationship_____Witnessed by_____

Internal Use Only

If patient or patient's representation refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below

Presented on_____Time_____

Name_____Signature_____

This agreement will be in effect for one (1) year from the above date signed.

Allergies:_____

LIST ALL MEDICATIONS/DOSE/TIMES PER DAY

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Do you drink alcohol?	Yes	No
If yes, drinks per day	_____	
Do you smoke cigarettes?	Yes	No
If yes, packs per day	_____	

FAMILY HISTORY

Vascular Disease	Yes	No
Phlebitis	Yes	No
Amputations	Yes	No
Cancer	Yes	No
Heart Disease	Yes	No

DO YOU HAVE SIGNIFICANT PROBLMES WITH THESE OTHER AREAS:

Walking in balance	Yes	No		Change in bladder control	Yes	No	
Fever/Chills	Yes	No		Blood in urine	Yes	No	
Loss of appetite	Yes	No		Abdominal pain	Yes	No	
Double/blurred vision	Yes	No		Blood in stool	Yes	No	
Ringing in ears	Yes	No		Constipation/Diarrhea	Yes	No	
Bloody nose/gums	Yes	No		Rashes	Yes	No	
Sore throat	Yes	No		Bruises	Yes	No	
Chest pain	Yes	No		Headache	Yes	No	
Palpitations	Yes	No		Dizziness	Yes	No	
Shortness of breath	Yes	No		Blackouts	Yes	No	
Cough	Yes	No		Numbness/Tingling	Yes	No	
Speech	Yes	No		Seizures	Yes	No	
Weight loss	Yes	No					

PAST MEDICAL HISTORY INCLUDES:

Diabetes	Yes	No		Liver Disease	Yes	No	
Hypertension	Yes	No		Rheumatoid Arthritis	Yes	No	
Hyperlipidemia	Yes	No		Frequent Infections	Yes	No	
High Cholesterol	Yes	No		Peptic Ulcer	Yes	No	
Stroke	Yes	No		Thyroid	Yes	No	
Cardiac Disease	Yes	No		Cancer	Yes	No	
Angina	Yes	No		Emphysema	Yes	No	
Bleeding Problems	Yes	No		Depression/Anxiety	Yes	No	
Anesthesia Problems	Yes	No		Asthma	Yes	No	

SURGICAL HISTORY:_____
_____
_____