PENNSYLVANIA VASCULAR ASSOCIATES

SOCIETY HILL VEIN CENTER

PATIENT INFORMATION

Date_____Date of Birth_____Age_____

Name_____

Address_____City_____State____

Zip code_____Social Security #_____

Home Phone_____Cell Phone_____

Patients Employer_____Work Phone_____

Marital Status____S____M____Wid____Sep____Div_____

Spouse Name_____Spouse Date of Birth_____

How did you hear about our office?_____

What Doctor referred you to our practice?_____

Referring Dr. Address_____

Referring Dr . Phone_____Fax#_____

PRIMARY Doctor_____

Primary Dr. Address_____

Primary Dr. Phone_____Fax#_____

Emergency Contact_____

Relationship to You_____Phone #_____

Please bring to the office with you the day of your visit. Thank you!

INSURANCE INFORMATION
(PLEASE PRINT)

NAME OF PRIMARY INSURANCE_____

ADDRESS_____

NAME OF SUBCRIBER_____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 needed to determine the benefits or 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 needed to determine these benefits payable for related services.

Signature_____Date_____

FOR PATIENTS WITH COMMERCIAL/ANY OTHER INSURANCE PLEASE READ AND SIGN.

To process my medical claims for payment I herby authorize Pennsylvania Vascular Associates, 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 HIPPA (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 t his 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.

PATIENT NAME:_____

ALLERGIES:_____

LIST ALL MEDICATIONS/DOSE/TIMES PER DAY

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Do you drink alcohol?	Yes	No
If yes, drink 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:_____

_____