ADVANCED VASCULAR ASSOCIATES

AdvancedVascular.com

Main Phone: 973-540-9700
Fax: (973) 540-9717

(Please print)

Today's Date: ____________________

Patient Information

Name: ____________________ First Name ____________ Middle ____________ Last Name

Date of Birth: ____________ Age: ________ Social Security #: ____________

Sex: ☐ M ☐ F   Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other ____________

Home Phone: ____________ Cellular: ____________

E-Mail: ____________________

Home Address:

Address: ____________________ Bldg/Apt #: ________

City: ____________ State: ____________ Zip Code: ________

Demographics

Race:
- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Other ____________

Primary Language:
- ☐ Italian
- ☐ English
- ☐ French
- ☐ Spanish
- ☐ Other ____________

Ethnicity:
- ☐ Hispanic
- ☐ Non-hispanic

Employer Information

Employer: ____________________

Address: ____________________

City: ____________ State: ____________ Zip Code: ________

Occupation: ____________ Work Phone: ____________

Emergency Notification

In case of emergency, who should be notified? ____________________

Relationship to patient: ____________________

Email: ____________________

Phone Numbers:

Home: ____________ Work: ____________ Cellular: ____________

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MEDICAL HISTORY

Today's Date: ______________________________

Patient Name: ______________________________ **DOB:** ______________

Physicians

1. Primary Care Physician ______________________ Phone# ______________

Address: ______________________________

2. Physician who referred you today ______________________ Phone# ______________

Address: ______________________________

3. Cardiologist (if applicable) ______________________ Phone# ______________

Address: ______________________________

4. Nephrologist (if applicable) ______________________ Phone# ______________

Address: ______________________________

5. Other Physician ______________________ Phone# ______________

Address: ______________________________

Dialysis Information (if applicable)

Type: ☐ HEMO-DIALYSIS ☐ PERITONEAL (PD)

Shift/Time of Dialysis: ______________________________

Days: ☐ MON ☐ TUES ☐ WED ☐ THUR ☐ FRI ☐ SAT

Dialysis Center: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Phone: (____) ______________________________

Nephrologist: ______________________________

ADVANCED VASCULAR - Medical History

Patient Name: ______________________________ DOB: ______________

Please CHECK all that apply to your history and add any conditions not listed

General:
- ☐ High Blood Pressure
- ☐ High Cholesterol

Vascular:
- ☐ Aneurysm (Body Location ______________)
- ☐ Blood Clots (Body Location ______________)
- ☐ Carotid Artery Disease
- ☐ Peripheral Artery Disease / ☐ Leg bypass surgery or stents
- ☐ Varicose Veins

Cardiac:
- ☐ Atrial Fibrillation / ☐ Other Heart Rhythm Problem /
- ☐ Pacemaker / Defibrillator (Chest Location: ☐Right ☐Left) Brand: ______________
- ☐ Coronary Artery Disease / ☐ Heart Attack
- ☐ Heart Bypass Surgery / ☐ Cardiac Stents
- ☐ Congestive Heart Failure
- ☐ Congestive Heart Disease
- ☐ Heart Valve Disease / ☐ Heart Murmur
- ☐ Heart Valve Surgery

Pulmonary:
- ☐ Asthma / ☐ COPD / ☐ Emphysema
- ☐ Oxygen Dependence
- ☐ Pneumonia
- ☐ Sleep Apnea

Neurological:
- ☐ Migraine Headache (Aura: Yes or No)
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Stroke
- ☐ TIA or Mini Stroke (Stroke-like symptoms that typically resolve in minutes)

Endocrine:
- ☐ Diabetes: ☐ Type I ☐ Type II
- ☐ Thyroid Disease

Renal:
- ☐ Dialysis Dependence
- ☐ Kidney Failure
- ☐ Kidney Disease (Type ______________)

Hematologic / Lymphatic:
- ☐ Anemia
- ☐ Blood or Clotting Disorder
- ☐ Cancer (Body Location ______________)
- ☐ Lymphedema

Gastrointestinal:
- ☐ Diverticular Disease
- ☐ GERD / Heartburn
- ☐ Hepatitis / Liver Disease (Type ______________)
- ☐ History of Stomach Ulcer
- ☐ Pancreatic Disease

Other:
- ☐ Arthritis / ☐ Spine Disease / ☐ Back Pain
- ☐ Autoimmune (Rheumatoid Arthritis, Lupus, Vasculiis)
- ☐ Chronic Pain / Fibromyalgia
- ☐ Depression / Anxiety
- ☐ Enlarged Prostate
- ☐ Gout
- ☐ HIV / AIDS
- ☐ Additional: ______________

SURGICAL HISTORY - (Please list all previous surgeries and year)

Date: __________ Procedure: ______________________________

Date: __________ Procedure: ______________________________

Date: __________ Procedure: ______________________________

Date: __________ Procedure: ______________________________

Date: __________ Procedure: ______________________________

ADVANCED VASCULAR - Medical History

Patient Name: ______________________________ DOB: ______________

SOCIAL HISTORY

CIGARETTE SMOKING: CURRENT : # PACKS PER DAY __________ # YEARS SMOKING __________
QUIT: # YEARS SINCE QUITTING __________ # YEARS SMOKING __________
☐ NEVER

CHEWING TOBACCO: ☐ YES ☐ NO ☐ PAST

ALCOHOL CONSUMPTION: ☐ NONE ☐ RARE
DRINKS / DAY ________ #DRINKS / WEEK ________ #DRINKS / MONTH ________

FAMILY HISTORY

Please check if applicable / provide relative:

☐ Aneurysm ________ ☐ Stroke ________ ☐ Blood clots ________ ☐ Blood Disorder ________

☐ Heart Disease ________ ☐ Sudden Death ________ ☐ Diabetes ________ ☐ Varicose Veins ________

Please list any other family medical history:

____

____

____

____

SYSTEM REVIEW
(CHECK ANY SYMPTOMS OCCURRING NOW OR WITHIN THE PAST MONTH)

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Weight gain
- ☐ None

Cardiovascular
- ☐ Chest pain
- ☐ Leg / ankle swelling
- ☐ None

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Pain with breathing
- ☐ Coughing up blood
- ☐ None

Gastrointestinal
- ☐ Abdominal pain
- ☐ Abdominal pain after meals
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ None

Genitourinary
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ None

Integumentary
- ☐ Dry skin
- ☐ Skin discoloration
- ☐ Skin ulcers
- ☐ Itching
- ☐ Rash
- ☐ None

Neurological
- ☐ Sudden muscle weakness
- ☐ Sudden paralysis or loss of feeling
- ☐ Sudden visual disturbance
- ☐ Sudden difficulty speaking or swallowing
- ☐ Dizziness / Vertigo
- ☐ Syncope (fainting spells)
- ☐ None

Musculoskeletal
- ☐ Leg pain with walking
- ☐ Leg pain at rest
- ☐ Back pain
- ☐ Joint pain
- ☐ None

Hematologic / Lymphatic
- ☐ Easy bleeding
- ☐ Enlarged lymph nodes
- ☐ None

Allergic / Immunologic
- ☐ Hives
- ☐ None

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MEDICATION RECONCILIATION

Name: ______________________

DOB: ______________________

Today's Date: ______________________

Pharmacy Name: ______________________

Pharmacy Town: ______________________

Pharmacy Phone #: ______________________

Facility: ______________________

____

ALLERGIES: REACTION:

(EX. DRUGS, FOOD, CONTRAST, NICKEL)

____

____

____

____

____

☐ NO KNOWN DRUG ALLERGIES

MEDICATION:	**DOSAGE:**	**TIMES:**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

UPDATED:

DATE: ______________________ DATE: ______________________

DATE: ______________________ DATE: ______________________

DATE: ______________________ DATE: ______________________

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Name: ______________________ **Date of Birth:** ____________

Insurance Information

1. Primary Insurance Carrier ____________ Subscriber Name ____________

   Subscriber Date of Birth ____________ ID # ____________

   Relationship to Patient ____________

2. Secondary Insurance Carrier ____________ Subscriber Name ____________

   Subscriber Date of Birth ____________ ID # ____________

   Relationship to Patient ____________

CLAIM AUTHORIZATION FOR HEALTH INSURANCE AND MEDICARE PATIENTS

HEALTH INSURANCE COMPANY:

"I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically-ralated facility to furnish any and all records, medical history, services rendered, or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to the Health Insurer

I also authorize the insurer to disclose to a hospital or health care service plan, self-insurer or an insurer any medical information obtained if such disclosure is necessary.

If my coverage is under Group Contract held by an employer, an association trust fund, union, or similar entity, this authorization also permits disclosure to them for the purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with the insurer including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents and or heirs, executors and administrators"

MEDICARE:

"I request the payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that Physician to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

AUTHORIZATION TO PAY:

"I request payment of this claim and, if the payor accepts assignment, authorize payment direct to the physician or supplier for the services described."

PATIENT'S RESPONSIBILITY

I authorize the physicians and medical personnel to provide necessary medical treatment. I verify the accuracy of afore-mentioned information, and I authorize the release of information as provided above. I agree that I am fully responsible to pay all fees charged by the Doctor, regardless of how much my insurance pays. If the Doctor accepts assignment, the deductible and co-payments are my responsibility. For Medicare; Medicare regulations will prevail.

I understand that all co-pays are to be paid at the time of service. I am in agreement with the "Authorization to Pay" and the "Patients Responsibility to Pay" statements made above.

______________________ Signature of Insured/Guardian

______________________ Date