



(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 Italian English
 Caucasian Hispanic French Spanish
 Other _____ 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: _____



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

| | |
|--|---|
| <p>General:</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> High Cholesterol</p> <p>Vascular:</p> <p><input type="checkbox"/> Aneurysm (Body Location _____)</p> <p><input type="checkbox"/> Blood Clots (Body Location _____)</p> <p><input type="checkbox"/> Carotid Artery Disease</p> <p><input type="checkbox"/> Peripheral Artery Disease / <input type="checkbox"/> Leg bypass surgery or stents</p> <p><input type="checkbox"/> Varicose Veins</p> <p>Cardiac:</p> <p><input type="checkbox"/> Atrial Fibrillation / <input type="checkbox"/> Other Heart Rhythm Problem /</p> <p><input type="checkbox"/> Pacemaker / Defibrillator (Chest Location: <input type="checkbox"/>Right <input type="checkbox"/>Left) Brand: _____</p> <p><input type="checkbox"/> Coronary Artery Disease / <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Heart Bypass Surgery / <input type="checkbox"/> Cardiac Stents</p> <p><input type="checkbox"/> Congestive Heart Failure</p> <p><input type="checkbox"/> Congestive Heart Disease</p> <p><input type="checkbox"/> Heart Valve Disease / <input type="checkbox"/> Heart Murmur</p> <p><input type="checkbox"/> Heart Valve Surgery</p> <p>Pulmonary:</p> <p><input type="checkbox"/> Asthma / <input type="checkbox"/> COPD / <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Oxygen Dependence</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Sleep Apnea</p> <p>Neurological:</p> <p><input type="checkbox"/> Migraine Headache (Aura: Yes or No)</p> <p><input type="checkbox"/> Peripheral Neuropathy</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> TIA or Mini Stroke (Stroke-like symptoms that typically resolve in minutes)</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>Endocrine:</p> <p><input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II</p> <p><input type="checkbox"/> Thyroid Disease</p> <p>Renal:</p> <p><input type="checkbox"/> Dialysis Dependence</p> <p><input type="checkbox"/> Kidney Failure</p> <p><input type="checkbox"/> Kidney Disease (Type _____)</p> <p>Hematologic / Lymphatic:</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Blood or Clotting Disorder</p> <p><input type="checkbox"/> Cancer (Body Location _____)</p> <p><input type="checkbox"/> Lymphedema</p> <p>Gastrointestinal:</p> <p><input type="checkbox"/> Diverticular Disease</p> <p><input type="checkbox"/> GERD / Heartburn</p> <p><input type="checkbox"/> Hepatitis / Liver Disease (Type _____)</p> <p><input type="checkbox"/> History of Stomach Ulcer</p> <p><input type="checkbox"/> Pancreatic Disease</p> <p>Other:</p> <p><input type="checkbox"/> Arthritis / <input type="checkbox"/> Spine Disease / <input type="checkbox"/> Back Pain</p> <p><input type="checkbox"/> Autoimmune (Rheumatoid Arthritis, Lupus, Vasculiis)</p> <p><input type="checkbox"/> Chronic Pain / Fibromyalgia</p> <p><input type="checkbox"/> Depression / Anxiety</p> <p><input type="checkbox"/> Enlarged Prostate</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> HIV / AIDS</p> <p><input type="checkbox"/> Additional: _____</p> <p>_____</p> <p>_____</p> |
|--|---|

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 _____ |
| | <input type="checkbox"/> NEVER |
| CHEWING TOBACCO: | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PAST |
| ALCOHOL CONSUMPTION: | <input type="checkbox"/> NONE <input type="checkbox"/> RARE |
| | # DRINKS / DAY _____ #DRINKS / WEEK _____ #DRINKS / MONTH _____ |

FAMILY HISTORY

Please check if applicable / provide relative:

| | | | |
|--|---|--|---|
| <input type="checkbox"/> Aneurysm _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Blood clots _____ | <input type="checkbox"/> Blood Disorder _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Sudden Death _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> 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



MEDICATION RECONCILIATION

Name: _____ **ALLERGIES:** _____ **REACTION:** _____

DOB: _____ (EX. DRUGS, FOOD, CONTRAST, NICKEL)

Today's Date: _____

Pharmacy Name: _____

Pharmacy Town: _____

Pharmacy Phone #: _____

Facility: _____

_____ 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: _____



Name: _____ Date of Birth: _____

Insurance Information form with fields for Primary and Secondary Insurance Carrier, Subscriber Name, Date of Birth, ID #, and 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-related 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 aforementioned 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



Name: _____ Date of Birth: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

| |
|--|
| Release Information From: Medical Facility (Name, Address, Phone): _____ _____ _____ |
|--|

| |
|--|
| Release Information To: ADVANCED VASCULAR ASSOCIATES 131 Madison Avenue, Second Floor Morristown, New Jersey 07960 |
|--|

PURPOSE OF RELEASE: Treatment / Continued Care

INFORMATION TO BE RELEASED:

| | | |
|--|--|---|
| REQUIRED - Please specify from below list or select entire medical chart | | |
| <input type="checkbox"/> Radiology Images and Reports | <input type="checkbox"/> Ultrasound Images and Reports | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Clinical Notes | <input type="checkbox"/> Cardiology Testing |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Billing Record |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Entire Medical Chart | <input type="checkbox"/> Other |

PHARMACY/MEDICATION HISTORY

I authorize Advanced Vascular Associates to obtain all of my medication history, as is medically necessary, in any format, to provide my medical care.

| | | | |
|---|-------|---|-------|
| SIGNATURE (REQUIRED) | | DATE SIGNED (REQUIRED - MONTH DD, YYYY) | |
| PRINTED NAME OF PERSON SIGNING (IF NOT PATIENT) | | RELATIONSHIP | |
| MAILING ADDRESS OF PATIENT - STREET | | | |
| CITY | STATE | ZIP CODE | PHONE |



**ADVANCED
VASCULAR
ASSOCIATES**

AdvancedVascular.com

Main Phone: 973-540-9700

Fax: (973) 540-9717

Name: _____ **Date of Birth:** _____

**AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION**

With my consent, Advanced Vascular Associates, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Advanced Vascular Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Advanced Vascular Associates, 131 Madison Avenue, Second Floor, Morristown, New Jersey 07960-7360.

With my consent, Advanced Vascular Associates may call, e-mail, or mail to my home or other designated location and leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance issues, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Advanced Vascular Associates may call, e-mail, or mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and to receive free health resources and periodic special offers from our offices.

By signing this form, I am consenting to Advanced Vascular Associates' use and disclosure of my protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO).

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Advanced Vascular Associates may decline to provide treatment to me.

| |
|---|
| <p>Is there a person that you authorize to receive/discuss you PHI? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please indicate name and relationship: _____</p> <p>Special Instructions: _____</p> |
|---|

Patient's Names (print) Date

Parent/Legal Guardian Name (print) Signature of Patient or Legal Guardian