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: ______________

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

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:

____

____

____

LIVING WILL OR ADVANCE DIRECTIVE: ☐ YES ☐ NO

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

AdvancedVascular.com

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

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: ______________________

ADVANCED VASCULAR ASSOCIATES
AdvancedVascular.com

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

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

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

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

☐ Radiology Images and Reports	☐ Ultrasound Images and Reports	☐ Laboratory Reports
☐ Operative Reports	☐ Clinical Notes	☐ Cardiology Testing
☐ Emergency Room Record	☐ Discharge Summary	☐ Billing Record
☐ Medications	☐ Entire Medical Chart	☐ Other

____

PHARMACY/MEDICATION HISTORY

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

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.

Is there a person that you authorize to receive/discuss your PHI? ☐ Yes ☐ No

Name: ______________________ Relationship: ______________________ Phone: ____________

Name: ______________________ Relationship: ______________________ Phone: ____________

Name: ______________________ Relationship: ______________________ Phone: ____________

____
Patient's Names (print) Date

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