ADVANCED VASCULAR ASSOCIATES

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☐ Amit V. Patel, MD
☐ Michael Resnikoff, MD
☐ Omer J. Riaz, MD
☐ Kevin V. James, MD
☐ Thomas Y. Lee, MD
☐ Brian D. Wernick, MD

Appt Date: _____

Appt Time: _____

☐ MORRISTOWN OFFICE ☐ POMPTON PLAINS OFFICE
☐ JEFFERSON OFFICE

Date: _____

Dear _____ ,

At Advanced Vascular Associates, your time is as valuable to us as it is to you. We encourage you to take time to complete the following **UPDATE** prior to your appointment, so that we may care for you promptly.

If you happen to misplace any of the provided forms, duplicates are available to download and print from our website at: www.advancedvascular.com.

Please bring the following forms and documents to your visit:

1. Completed Patient Update Forms - Two (2) Pages
2. All Health Insurance Cards
3. Photo Identification (ie. Driver's License)
4. Current list of Medications with dosages and times taken
5. Any Test Results
6. Insurance Payments (ie. Copays, Deductibles, etc,)
7. Any Insurance Referrals

Please note: Our facility requires an update to your healthcare information every six (6) months.

If you have any questions concerning this matter, please feel free to contact this office at 973-540-9700.

Thank you.
Advanced Vascular Associates

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AdvancedVascular.com

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

PATIENT UPDATE FORM - EVERY 6 MONTHS

Last Visit Date: **Today's Date:**

Patient Information:

Name:
First Name Middle Last Name

Date of Birth: Age: Last 4 Digits of SSN:

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

Home Phone: Cell Phone:

Email:

Home Address: Bldg/Apt #:

City: State: Zip Code:

Do you have a Living Will or Advance Directive? ☐ Yes ☐ No

Medical History:

Primary Care Physician:

Cardiologist: Nephrologist:

Any new medical conditions since your last visit?

Any new surgeries since your last visit?:

Patient's Name (print) Date:

Signature of Patient or Legal Guardian:

Parent or Legal Guardian (print):

Reviewed by: Date:

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MEDICATION RECONCILIATION

Name: _____ ALLERGIES: REACTION:

DOB: _____ _____

Today's Date: _____ _____

Pharmacy Name: _____ _____

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: _____