# New Patient Registration

ELITE VASCULAR CARE

## Patient Information

**Patient Name**

_____

First MI Last

DOB _____ SS# _____

Marital Status_____ ○ MALE ○ FEMALE

Address _____

_____

Home Phone _____ Cell _____

Work Phone _____

Employer _____

Occupation _____

Name of Spouse _____

Address: _____

_____

○ Check if same as patient's address

Race

○ American Indian or Alaska Native ○ Asian
○ Native Hawaiian ○ Black or African American ○ White
○ Other Pacific Islander ○ Prefer not to answer

Ethnicity

○ Hispanic/Latino ○ Non-Hispanic/Latino
○ Prefer not to answer

Preferred Language

○ English ○ Spanish ○ Other _____

Preferred Pharmacy _____

Location _____

Family Doctor _____

Phone _____

## Insurance Information

**Primary Insurance Co** _____

Policy #: _____

*Policy holder information, if not same as patient:*

Name _____

DOB _____ SS# _____

**Secondary Insurance Co** _____

Policy #: _____

*Policy holder information, if not same as patient:*

Name _____

DOB _____ SS# _____

## Complete below if patient is a minor

**Father's Name (or Guardian)** _____

DOB _____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

○ Check if same as patient's address

Employer _____

**Mother's Name (or Guardian)** _____

DOB _____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

○ Check if same as patient's address

Employer _____

ELITE VASCULAR CARE

# New Patient Registration

## HIPAA Release

**Patient Name**

First MI Last

Do you have a Living Will? ◯ Yes ◯ No
Do you have an Advance Directive? ◯ Yes ◯ No
*If you answered yes to either, please provide us a copy.*

**Emergency Contact:**

Name Relationship

Phone #

**I authorize Elite Vascular Care to discuss my healthcare information with the below:**

Name Relationship

Phone #

Name Relationship

Phone #

**Preferred appointment reminder notification:**
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail/Portal ◯ None
◯ With the person(s) authorized above

**Preferred medical information notification:**
***I authorize Elite Vascular Care to leave a detailed message which may contain personal health information via:***
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail/Portal ◯ None
◯ With the person(s) authorized above

**Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.**

***Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.***

# YOU MUST READ BELOW FOR IMPORTANT INFORMATION AND NOTICES

## Financial Policy

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of-pocket, deductibles and noncovered services.

I authorize the payments from my insurance company(s) according to my medical benefits be made payable to ***Elite Vascular Care*** for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Elite Vascular Care as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

***NOTE: You will electronically sign for this Financial Policy agreement on the signature pad in your doctors' office to be stored in your electronic medical chart.***

## Notice of Privacy Practices

I acknowledge that I have received a copy of the **Provider Notice of Privacy Practices** for Elite Vascular Care. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Elite Vascular Care with respect to my protected health information.

***NOTE: You will electronically sign for this Notice of Privacy Practices on the signature pad in your doctors' office to be stored in your electronic medical chart.***

## Consent to Obtain External Prescription History

I authorize Elite Vascular Care and its physicians and staff to view my external prescription history via the electronic medical records system Medent, and the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. **MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.**

***NOTE: You will electronically sign for this Consent to Obtain External Prescription History on the signature pad in your doctors' office to be stored in your electronic medical chart.*** **You will have the option to give consent or deny this access upon electronically signing.**

## Community Chart Consent

I give consent to Elite Vascular Care to access the Community Chart in order to access and share my medical records if available through other entities operating under the Carequality Interoperability Framework, including Surescripts. This includes demographic information as well as other relevant clinical documentation.

***NOTE: You will electronically sign for this Community Chart Consent on the signature pad in your doctors' office to be stored in your electronic medical chart.*** **You will have the option to give consent or deny this access upon electronically signing.**

Patient Name_____DOB_____

Allergies to Medications, X-Ray Dyes, or other Substances: ☐ No ☐ Yes

Type of Allergy: _____

List of Current Medications:

_____

_____

_____

_____

_____

_____

Past Medical History and Review of Systems

(Please check off if you have had any problems with or are presently experiencing any of the following)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Chest Pain / Tightness
- ☐ Shortness of Breath
- ☐ Swollen Ankles
- ☐ Palpitations
- ☐ Lightheadedness
- ☐ Frequent Urination
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ TB
- ☐ Persistent Cough
- ☐ Abdominal Discomfort
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Ulcers
- ☐ Change in Bowel Habits
- ☐ Unexplained Weight Gain / Loss
- ☐ Hemorrhoids
- ☐ Gall Bladder Disease
- ☐ Colitis
- ☐ Hepatitis of Jaundice
- ☐ Thyroid Disease
- ☐ Head or Neck Radiation
- ☐ Headache
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Difficulty Urinating
- ☐ Arthritis
- ☐ Low Back Problems
- ☐ Gout
- ☐ Skin Diseases
- ☐ Blood Disorders
- ☐ Venereal Diseases
- ☐ Anxiety
- ☐ Depression
- ☐ Anemia
- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ Impotence or Erectile Disfunction
- ☐ Other

_____

_____

_____

_____

_____

_____

_____

Surgeries and Dates

_____
_____
_____
_____
_____

| Family History | Mother | Father | Sibling |
|---|---|---|---|
| ☐ Cancer (type) | _____ | _____ | _____ |
| ☐ Hypertension | _____ | _____ | _____ |
| ☐ Diabetes | _____ | _____ | _____ |
| ☐ Stroke | _____ | _____ | _____ |
| ☐ Anxiety / Depression | _____ | _____ | _____ |
| ☐ Drug / Alcohol Addiction | _____ | _____ | _____ |
| ☐ Glaucoma | _____ | _____ | _____ |
| ☐ Bleeding Diseases | _____ | _____ | _____ |
| ☐ Other | _____ | _____ | _____ |

Habits

| | | | |
|---|---|---|---|
| ☐ Smoking | Duration_____ | Amount _____ | Quit/When_____ |
| ☐ Alcohol | Duration_____ | Amount_____ | Quit/When_____ |
| ☐ Coffee/Caffeine | Duration_____ | Amount_____ | Quit/When_____ |
| ☐ Drugs | Duration_____ | Amount_____ | Quit/When_____ |