PATIENT NAME: ______________________________ ☐Male ☐Female

Last First Middle

DATE OF BIRTH: ______________ SOCIAL SECURITY #: ______________

ADDRESS: ______________________________

CITY: ______________ STATE: ______________ ZIP: ______________

HOME PHONE: ______________ CELL PHONE: ______________ E-MAIL: ______________

☐ Please enroll me in your patient portal. Once done, I am aware I will receive an email with instructions at the email listed above.

MARITAL STATUS: ☐Married ☐Single ☐Divorced ☐Widowed RACE: ______________

EMPLOYMENT STATUS: ☐Retired ☐Full-Time ☐Part-Time ☐Disability ☐Other: ______________

EMPLOYER: ______________ EMPLOYER PHONE #: ______________

PRIMARY CARE PHYSICIAN: ______________ REFERRING DR: ______________

PHARMACY: ______________ LOCATION: ______________

RESPONSIBLE (OR INSURED) PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

RESPONSIBLE (OR INSURED) PARTY NAME: ______________________________

Last First Middle

DATE OF BIRTH: ______________ SOCIAL SECURITY NUMBER: ______________

ADDRESS: ______________________________

CITY: ______________ STATE: ______________ ZIP: ______________

HOME PHONE: ______________ CELL PHONE: ______________ EMAIL: ______________

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: ______________________________

ID #: ______________ GROUP #: ______________

PATIENT RELATIONSHIP TO SUBSCRIBER: ☐Self ☐Spouse ☐Child ☐Other ______________

SUBSCRIBER NAME: ______________ SUBSCRIBER DATE OF BIRTH: ______________

SECONDARY INSURANCE NAME: ______________________________

ID #: ______________ GROUP #: ______________

PATIENT RELATIONSHIP TO SUBSCRIBER: ☐Self ☐Spouse ☐Child ☐Other ______________

SUBSCRIBER NAME: ______________ SUBSCRIBER DATE OF BIRTH: ______________

EMERGENCY CONTACT INFORMATION

NAME: ______________ RELATIONSHIP: ______________ PHONE: ______________

Patient Name: ____________________________

Date of Birth: ________________________

AUTHORIZATION FOR TREATMENT

- I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care, and by doing so also authorize the order of ancillary services deemed necessary for my treatment and care.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my healthcare provider and to ask and have answered to my satisfaction any questions or concerns.
- In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV, hepatitis B virus, or hepatitis C virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Virginia Law.
- I understand that Commonwealth Vascular Institute utilizes an electronic medical record system and this system is maintained in accordance with HIPAA and other patient privacy and health information management regulations.
- I understand that Commonwealth Vascular Institute utilizes an electronic prescribing mechanism for electronic transmission of prescriptions to my local pharmacies and mail order pharmacies. I consent to the release of my prescription history from any pharmacy or drug monitoring agency to my physician.

PAYMENT ARRANGEMENTS

- I agree to be responsible for payment of all services rendered to me or my dependents.
- By signing this document, I authorize the assignment to the Medical Practice of all payments under any insurance benefits otherwise payable to me for services provided under **any** insurance policy.
- By signing this document, I authorize the release of my Protected Health Information (PHI) to my insurance companies or other third party payers, including their representatives, as necessary to determine coverage or as required for review, quality improvement, and/or management.
- I agree to pay, at the time of service, any required co-payments, co-insurance and deductibles, as well as charges for services not covered by my insurance.
- I understand that I am responsible for paying the balance of my bill in full unless other arrangements have been approved in advance and that all unpaid balances will be billed to my address on file.
- I understand that there is a $50 charge for returned checks.
- I understand that past due accounts will be referred to a collection agency and that I will be responsible for all collection charges, associated legal fees, and the full balance on my account.
- By signing this document, I agree that photocopies of this document are as legally binding as the original.

I have read, understand and agree to the above terms

____ ____________________

Signature of Patient or Guarantor **Date**

____

Printed Name

PRIVACY AND DISCLOSURE
Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose your personal health information. By signing below, you acknowledge that you have received a copy of our NPP.

____ ___________________________ ____________________

Patient or Guarantor Signature **Relationship to patient** **Date**

____

Printed Name

Patient Name: ______________________________

Date of Birth: _________________________

Permission to Disclose Private Health Information (PHI)

By signing below, I give permission to the person(s) listed to receive Private Health Information or other authorization as listed. I understand this form is legally binding and that I may revoke my authorization at any time by submitting, by request, to change, add, or terminate such permission in writing.

NAME	RELATIONSHIP	PHONE NUMBER

ADVANCE CARE PLAN

Do you have an advance care plan or directive? ____

Who is your surrogate decision maker? ____________________________ Relationship: ________________

Would you like further information on creating a plan? ☐Yes ☐No

Signature of Patient or Guardian: _________________________________ Date: ___________________

COMMONWEALTH VASCULAR INSTITUTE

Patient Name: ______________________________

Date of Birth: ________________________

Medication Form

Please list medications (include any over-the-counter medications, as well as vitamins, herbs, and supplements), the dose and how often you take the medication.

☐ Please see attached medication list

Medication	Dose	Frequency

ALLERGIES: Please list all allergies you have, including to foods. Please indicate the type of reaction you had.

ALLERGY	**REACTION**

OFFICE USE ONLY:

Reviewed date & initials	*Updated & initials*	*Updated & initials*

Patient Name: ______________________________

Date of Birth: ________________________

Preventative Health Questionnaire

DIAGNOSTIC TESTS:

Colonoscopy: Have you ever had a colonoscopy? ☐Yes ☐No

Date last performed ___________________ ☐Unknown date

Results: ☐Unknown ☐Normal ☐Abnormal ☐Other: ______________________________

Mammogram: Have you ever had a mammogram? ☐Yes ☐No

Dater last performed ___________________ ☐Unknown date

Results: ☐Unknown ☐Normal ☐Abnormal ☐Other: ______________________________

VACCINES*:*

Flu: Have you ever received the flu vaccine? ☐Yes ☐No

Date last received? ___________________ ☐Unknown date

Pneumonia: Have you ever received the pneumonia vaccine? ☐Yes ☐No

Date last received? ___________________ ☐Unknown date

Tetanus: Have you ever received the Tetanus vaccine? ☐Yes ☐No

Date last received? ___________________ ☐Unknown date

Shingles: Have you ever received the Shingles vaccine? ☐Yes ☐No

Date last received? ___________________ ☐Unknown date

COVID-19: Have you ever received the one or both vaccines? ☐Yes ☐No

Vaccine #1 ______________ ☐Unknown date Vaccine #2 _____________ ☐Unknown date

FAMILY HISTORY:

Father ☐ Living ☐ Deceased Cause of Death: ______________________________

List any health issues your father has/had: ______________________________

Mother ☐ Living ☐ Deceased Cause of Death: ______________________________

List any health issues your mother has/had: ______________________________

Signature: ______________________________ Date: ___________________