COMMONWEALTH VASCULAR INSTITUTE

PATIENT NAME: _____ ☐Male ☐Female
Last First Middle

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ E-MAIL: _____

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 NAME: _____ PHARMACY LOCATION: _____

INSURED/RESPONSIBLE 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: _____

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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

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Permission to Disclose Private Health Information (PHI)

Patient Name: _____ Date of Birth: _____

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: _____

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Patient Name: _____ Date of Birth: _____

MEDICATIONS

Very important please make sure you list all your medications including over the counter medications.

☐ **SEE ATTACHED MEDICATION LIST**

NAME OF MEDICATION	DOSAGE OF MEDICATION	HOW OFTEN DO YOU TAKE

ALLERGIES

Do you have a LATEX allergy? ☐NO ☐YES
Do you have an allergy to IODINE/DYE? ☐NO ☐YES
Do you have a shellfish allergy? ☐NO ☐YES
Please list any DRUG and FOOD allergies, if NONE please circle: ☐No known drug allergies

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

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PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

HEIGHT _____ WEIGHT _____ ☐Right-handed ☐Left-handed

Communication Needs? ☐NO ☐YES --- Type: ☐speech ☐deaf ☐blind ☐other: _____

Assisting Family member name/relationship & phone number: _____

Does that patient reside in a nursing facility? ☐NO ☐YES --- Facility name: _____

MEDICAL HISTORY

Please mark any of the following you have been diagnosed with

☐High Blood Pressure	☐Asthma	☐Irregular Heartbeat	☐Sleep Apnea
☐High Cholesterol	☐COPD	☐Heart Disease	☐Stroke
☐Thyroid Disease	☐Pulmonary Embolism	☐Heart Attack	☐Anxiety Or Depression
☐Anemia	☐Skin Disorders	☐DVT/blood clot	☐Dementia
☐Stomach/Gi Problems	☐HIV/AIDS	☐Parkinson's disease	☐Alzheimer's
☐Osteoarthritis	☐Hepatitis	☐Seizure Disorder	☐Aortic Aneurysm
☐Cancer, _____ _____	☐Peripheral Vascular Disease	☐Liver/Gallbladder Disease	☐Diabetes ☐*Type I* ☐*Type II*
☐Kidney disease, stage: _____	If on dialysis: ☐ Mon/Wed/Fri -OR- ☐Tues/Thurs/Sat		

**Please list any other health issues you have that are not listed above:*

_____

_____

SURGICAL HISTORY

☐Appendix removal
☐Biopsy _____
☐CABG
☐Cataract Removal
☐Gallbladder removal
☐Coronary Artery Stent
☐Hemorrhoid(s) removal
☐Hernia Repair
☐Joint Replacement
☐Carotid Endarterectomy
☐Pacemaker
☐Hysterectomy
☐C-Section
☐Sinusectomy
☐Tonsil/Adenoidectomy
☐Vein Stripping ☐Vein Closures
☐Aortic Aneurysm Repair

Other(s) not listed above: _____

_____

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DIAGNOSTIC TESTING & IMMUNIZATIONS

Patient Name: _____ Date of Birth: _____

Have you ever had a colonoscopy? ☐NO ☐YES DATE: _____
Results: _____

Have you ever had a mammogram? ☐NO ☐YES DATE: _____
Results: _____

Have you had a Flu vaccine? ☐NO ☐YES DATE: _____
Have you had a Pneumonia vaccine? ☐NO ☐YES DATE: _____
Have you had a Tetanus vaccine? ☐NO ☐YES DATE: _____
Have you had a Shingles vaccine? ☐NO ☐YES DATE: _____
Have you had a COVID-19 vaccine? ☐NO ☐YES #1: _____ #2: _____
Booster #1: _____ Booster #2: _____

SOCIAL HISTORY

Do you smoke or use smokeless tobacco? ☐NO ☐YES Type of Product: _____
How much per day: _____
How long have you been using these products? _____
Have you ever smoked? ☐NO ☐YES If you quit, date: _____

Do you consume alcohol? ☐NO ☐YES What type? _____
How much do you drink? ☐Monthly ☐Daily ☐Socially

Do you use illicit drugs? ☐NO ☐YES What type? _____
How often? ☐Monthly ☐Daily ☐Socially

FAMILY HISTORY

	LIVING	CAUSE OF DEATH	ADDITIONAL ILLNESSES
MOTHER	☐NO ☐YES	_____	_____
FATHER	☐NO ☐YES	_____	_____