Vascular Institute of Virginia

14085 Crown Court, Woodbridge, VA 22193
Phone: 703-763-5224 Fax: 703-763-5374

REGISTRATION INFORMATION

(Please fill out forms and return via email or print forms and bring with you to the office)

Name: ____
(Last, First, M.I.)

D.O.B.:_____/_______/________ **Social Security #:** _____-_____-_____

Address: ____**P.O. Box:** __________

City:__________________________________ **State:** _________ **Zip:**___________

E-mail: ____

Home phone: ________________________ May we leave a message? _________

Cell phone: __________________________

Employer: _______________________________ **Work #:** ___________________

Primary Insurance: ____

Policy ID: _________________________ **Group #:** ________________________

Secondary Insurance: ____

Policy ID: _________________________ **Group #:** ________________________

Marital Status: Single Married Divorced Widowed Separated

Spouse's Name: ____________________ **Spouse's phone:** ________________

Emergency Contact: __________________________ **Phone:** _______________

To whom may we show our appreciation for referring you? _____________________

Primary Physician: ________________________ **Phone:** ___________________

Nephrologist: ____________________________ **Phone:** ___________________

Other: __________________________________ **Phone:** ___________________

Are you allergic to any Drugs/Medications: NO YES

If yes, please list: ____

Signature: ____________________________**Today's Date:** _______________

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FOR OFFICE USE ONLY

MEDICAL QUESTIONNAIRE

Name: ____

Age: __________

Sex: Male Female

Do you have any general allergies or allergies to medications? Yes No

If yes, please list and describe reaction: ________________________________

____

____

List all previous surgeries: ________________________________

____

____

____

List all current medications: ________________________________

____

____

____

____

____

Do you smoke? No Yes How much? How long?

Do you drink alcohol? No Yes # Drinks/day:

Do you use marijuana, cocaine, or other recreational drugs? No Yes

Do you use a: cane? walker? wheelchair?

Are you or could you be pregnant? Yes No

Date of your last menstrual cycle: ____________________________

Do you, or have you ever had cancer? Yes No Type? ____________________

Do you have a family history of cancer? No Yes

If yes, what family member and what type? ____________________________

REVIEW OF SYSTEMS

Do you have any problems now or have you had any related to the following systems? Indicate Yes or No

GENERAL HEALTH	YES	NO
Dentures		
Glasses/Contacts		
Hard of Hearing		
HEIGHT: WEIGHT:		
EYES		
Glaucoma		
Cataracts		
CARDIOVASCULAR		
Open Heart Surgery Type:		
High Blood Pressure		
Chest Pain		
Heart Attack		
Irregular Heartbeat		
Heart Murmur		
Pacemaker		
Defribrillator		
Congestive Heart Failure		
Mitral Valve Prolapse		
Rheumatic Fever		
Peripheral Arterial Disease (PAD)		
PSYCHOLOGICAL		
Anxiety		
Depression		
Other:		
GENITOURINARY		
Blood in Urine		
Nocturia (getting up at night)		
Urinary Frequency (>8 times/day)		
Urinary Tract Infection		
Urinary Leakage		
Kidney Stones		
Kidney Disease		
Dialysis Days?		
Comments:		
ENDOCRINE		
Diabetes		
Thyroid Condition		
Comments:		

MUSCULOSKELETAL	YES	NO
Muscle Weakness		
Joint Pain (Swelling)		
Arthritis		
History of Orthopedic Surgery		
Chronic Back Pain/Injury		
Chronic Neck Pain/Injury		
Comments:		
NEUROLOGICAL		
Tremors		
Dizzy Spells		
Numbness/Tingling		
Stroke		
Seizures		
TIA's		
Comments:		
HEMATOLOGIC/LYMPHATIC		
Blood Clotting Problem		
Easy Bleeding/Bruising		
Anemia		
Sickle Cell Trait or Disease		
Enlarged Lymph Nodes		
Blood Transfusion History		
Immune Deficiency		
Hepatitis Type:		
HIV		
RESPIRATORY		
Asthma/COPD		
Chronic Cough		
Shortness of Breath		
Emphysema		
Exposure to Tuberculosis		
Pneumonia		
Bronchitis		
Sleep Apnea/CPAP use		
Comments?		
GASTROINTESTINAL		
Abdominal Pain		
Nausea/Vomiting		
Indigestion/Heartburn /GERD		
Constipation		
Diarrhea		
Bloody or Dark Stools		
Ostomy Bag		
Comments:		

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Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between the Vascular Institute of Virginia (VIV-the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform VIV of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current.
- Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When VIV receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).

Returned Check Policy:
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the Patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check, VIV will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance (in addition to the $25.00 returned check Service Charge).

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please print) ____

Patient Signature ________________________________ Date _______________

Responsible Party Name (Please print) ________________________________

Responsible Party Signature _________________________ Date _______________

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Release of Medical Information

Date: ___________________

To: Medical Records

From: Medical Records

Patient Name: ____

Patient's DOB: ____________________________________

I authorize any licensed physician, medical practitioner, pharmacist, psychiatrist, psychologist, or other mental health care provider, hospital, clinic or other medical or medically-related facility, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment of me and any non-medical information about me, to give any and all such information to Vascular Institute of Virginia.

____ ____________________________

Signature of patient or authorized representative Date

____

Printed name

Specific Request:

____

____

____

____

____

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Acknowledgment of Receipt of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices

____ _____________________________

Signature of Patient/Patient Representative Date

____

Relationship to Patient

Documentation of Good Faith Efforts

To Obtain patient's acknowledgement that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient)

The patient presented to the office on ___________ and was provided with a copy of Vascular Institute of Virginia's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

Patient refused to sign.

Patient was unable to sign or initial because:

____

Patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.

Other reason (describe below):

____

Signature of Employee completing form: ______________________________________

Date signed: ______________________