PATIENT REGISTRATION INFORMATION

DATE_____

PATIENT FULL NAME_____

DATE OF BIRTH_____AGE_____ MALE ___ FEMALE ___

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME #_____ CELL #_____

MARITAL STATUS ____SINGLE ___MARRIED ____DIVORCED ____WIDOWED

EMAIL_____ LANGUAGE_____

- ✓ Your Email is for the patient portal – your online connection to your records.

RACE: ____WHITE ____AFRICAN AMERICAN ____ AMERICAN INDIAN _____ HISPANIC

OTHER_____

ETHNICITY: _____HISPANIC ____NON HISPANIC

REFERRING PROVIDER_____MD / DO / PA / NP

PRIMARY CARE PROVIDER_____MD / DO / PA / NP

EMPLOYER_____

EMERGENCY CONTACT _____Phone#_____

Relationship_____

INSURANCE INFORMATION:

PLEASE PRESENT YOUR INSURANCE CARD (S) AND DRIVERS LICENSE OR PICTURE ID TO THE RECEPTIONIST

IS THIS WORK RELATED? YES____NO____ IS THIS AN AUTO ACCIDENT? YES____NO____
IF YES, PLEASE BRING YOUR CLAIM #

PRIMARY
INSURANCE_____

ID #_____GROUP#_____

SUBSCRIBER IS SELF_____ SPOUSE_____ If spouse, Spouse's DOB (required)_____

SECONDARY
INSURANCE_____

ID #_____GROUP#_____

SUBSCRIBER IS SELF_____ SPOUSE_____ If spouse, Spouse's DOB (required)_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give consent for VCNM to use, disclose and receive protected health information (PHI) about me to carry out treatment, payment, and health care operations. VCNM's notice of privacy provides a more complete description of uses and disclosures and I am aware that the Vascular Center of Northern Michigan (VCNM) has a copy of the notice of privacy practices for me to review upon request.

I have the right to review the notice of privacy practices prior to signing this consent. VCNM reserves the right to revise its notice of privacy practices at any time. A current copy of the notice of privacy practices may be obtained by forwarding a written request to VCNM office at 3930 Cedar Run Road, Traverse City, MI 49684

With this consent, VCNM may mail or call my home or other alternative location (that I name) and leave a message in reference to any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, test results, insurance/payment information and appointment information.

With this consent, VCNM has my permission to release any and all medical information to the following person (other than your doctors) (Re: information such as: surgical, diagnostic testing, billing, etc.)

Name of HIPAA representative _____

Phone#_____ Relationship_____

Check box if Emergency Contact is same as HIPAA ☐

I have the right to request that VCNM restrict how it uses or discloses my PHI to carry out treatment, payment and health care operations. The practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to VCNM use and disclosure of my PHI to carry out treatment, payment, and health care operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, VCNM may decline to provide treatment to me. By signing this consent, I am acknowledging receipt of this practice's notice of privacy practices for review.

Signature_____Date_____

FINANCIAL RESPONSIBILITY

- The Vascular Center of Northern Michigan participates with Medicare, Blue Cross and Blues Shield, Blue Care Network, Priority Health, Cofinity, Tricare, Medicare Advantage, BCN Advantage, Cigna, Aetna, Humana, Medicaid, Meridian, and McLaren. We accept the approved amount for services rendered as designated by the insurance company, excluding any co-pays, co-insurances and or deductibles, which time this becomes the patient's responsibility.
- Vascular Center of Northern Michigan will bill your insurance carrier. Any co-pays will be collected at the time of service.
- After billing your insurance or insurances any remaining balance will be forwarded to you and becomes your financial responsibility.
- **NO INSURANCE** – If you have no insurance coverage you are responsible for all services rendered at the time of your visit – VCNM and you should discuss the *approximate* amount of your visit and it will be noted in your chart. We do offer **financial arrangements, but they must be made prior to your appointment.** We do accept Visa and Master Card for your convenience.
- I hereby authorize my insurance carrier to make payment for service rendered directly to VCNM. The remaining balance will become my responsibility.
- I hereby authorize the VCNM to release any information acquired in the course of my examination or treatment to my insurance carrier, attending physician or Attorney in order to obtain payment.
- I understand I am fully responsible for all charges incurred whether or not paid by my Insurance carrier. I have read and agree to the terms and financial policies stated above.

- **Signature_____Date_____**

Name:_____ Date of Birth:_____

- Please mark **ALL** of the bubbles – do not leave any unmarked

Constitutional			**Genitourinary**		
fever	O Yes	O No	difficulty urinating	O Yes	O No
chills	O Yes	O No	increased urinary frequency	O Yes	O No
night sweats	O Yes	O No			
sleeping problems	O Yes	O No	**Constitutional**		
			blood in Urine	O Yes	O No
Ophthalmology			burning with urination	O Yes	O No
diminished vision	O Yes	O No			
drainage from eyes	O Yes	O No	**Neurology**		
blurring of vision	O Yes	O No	headache	O Yes	O No
			seizures	O Yes	O No
ENT/Respiratory					
cold	O Yes	O No	**Musculoskeletal**		
cough	O Yes	O No	leg cramps	O Yes	O No
hearing loss	O Yes	O No	back pain	O Yes	O No
frequent sinus infections	O Yes	O No	joint pain	O Yes	O No
Cardiology			**Endocrinology**		
shortness of breath	O Yes	O No	fatigue	O Yes	O No
palpitations	O Yes	O No	cold intolerance	O Yes	O No
chest pain	O Yes	O No	heat intolerance	O Yes	O No
Gastroenterology			**Psychology**		
abdominal pain	O Yes	O No	anxiety	O Yes	O No
gas	O Yes	O No	depression	O Yes	O No
heartburn	O Yes	O No			
nausea	O Yes	O No			
vomiting	O Yes	O No			
constipation	O Yes	O No			

MEDICAL HISTORY

NAME_____ DATE OF BIRTH _____
HEIGHT_____

PRESCRIPTION MEDICATIONS (BRING LIST IF YOU HAVE ONE) **No Meds _____**

NAME	DOSE (MG) FREQUENCY	NAME	DOSE (MG) FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NONPRESCRIPTION MEDICATIONS

___ANTACIDS ____ASPRIN 81mg____ASPRIN 325mg _____ TYLENOL _____DIET PILLS____
HERBAL SUPPLEMENTS _____VITAMINS_____ OTHER: _____

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY) **NO MEDICAL HISTORY _____**

___GLAUCOMA	___DIABETES	___VARICOSE VEINS
___TUBERCULOSIS	___HYPOTHYROIDISM	___ASTHMA
___EMPHYSEMA/COPD	___STROKE	___ULCER / GASTRITIS
___BLOOD DISORDER	___MIGRAINES	___SCARLET FEVER
___HEART MURMUR	___RHEUMATIC FEVER	___HIGH CHOLESTEROL
___HIGH BLOOD PRESSURE	___SKIN CONDITION	___KIDNEY STONES
___IRREGULAR HEART BEAT	___ARTHRITIS	___HEART VALVE DISEASE

___PERIPHERAL VASCULAR DISEASE (PVD)

CANCER
(TYPE)_____WHEN_____
OTHER_____

MEDICATION ALLERGIES **NO KNOWN MEDICATION ALLERGIES _____**

NAME _____ REACTION _____
NAME _____ REACTION _____
NAME _____ REACTION _____

PREFERRED PHARMACY_____LOCATION_____

TURN PAGE OVER

PREVIOUS SURGICAL HISTORY **NO SURGERIES _____**

PROCEDURE	**DATE**	**PROCEDURE**	**DATE**
CAROTID ENDARTERECTOMY	RT / LT _____	CORONARY ARTERY BYPASS	_____
ANEURYSM	_____	JOINT REPLACEMENT	_____
CATARACT REMOVAL	RT / LT _____	APPENDECTOMY	_____
HYSTERECTOMY	_____	TUBAL LIGATION/VASECTOMY	_____
MASTECTOMY	RT / LT _____	PROSTATE SURGERY	_____
THYROID SURGERY	_____	CHOLECYSTECTOMY (GALLBLADDER)	_____
VEIN STRIPPING	RT / LT _____	VEIN SCLERO	RT / LT _____

OTHER SURGICAL PROCEDURES_____
_____

FAMILY HISTORY - PLEASE IDENTIFY *PARENTAL MEMBER(S)* FOR ALL THAT APPLY

HIGH BLOOD PRESSURE_____ DIABETES_____
HEARTDISEASE_____ HEPATITIS_____
THYROID DISEASE_____ HIGH CHOLESTEROL_____
SKIN CANCER_____ BREAST CANCER_____
LUNG CANCER_____ COLON CANCER_____
OSTEOPOROSIS_____ MENTAL ILLNESS_____
ALCOHOLISM_____ OTHER_____
ADOPTED FAMILY HX IF UNKNOWN _____

PARENTS
FATHER: AGE_____ LIVING / DECEASED -CAUSE_____
MOTHER: AGE_____ LIVING / DECEASED -CAUSE_____

SOCIAL HISTORY
OCCUPATION_____FULL TIME____ PARTTIME____ RETIRED____
EVER SMOKE? YES / NO PIPE___ CIGARETTES____ PACK(S) PER DAY_____
YEARS SMOKING_____ DATE QUIT_____
MARITAL STATUS ___S ____M ___D ___W NUMBER OF CHILDREN_____
ALCOHOL HISTORY None____ Occasionally ____ Daily ____ Drinks per week _____
IV DRUG USE EVER? YES / NO WHEN_____ TYPE_____
MARIJUANA USE? YES/NO
REGULAR EXERCISE YES / NO (TYPE) _____
FOREIGN TRAVEL IN THE LAST YEAR? YES / NO
WHERE / WHEN_____

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