INTEGRATED VASCULAR VEIN CENTER
PATIENT REGISTRATION FORM

Today's Date: / /	Primary Care Physician:	
	Phone:	Fax:

PATIENT INFORMATION

Legal name as printed on Driver's License: (Please print)				
Last:		First:		Middle:
☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Alias / Nickname:		
Birth date: / /	Age:	Sex: ☐ M ☐ F	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐	
Do you have an Advance Directive? ☐ Yes ☐ No			Authorized Power of Attorney ☐ Yes ☐ No	
Race: ☐ Asian ☐ Black ☐ White ☐ Hispanic/Latino ☐ Native American ☐ Pacific Isle ☐ Other ☐ Refused				
Language: ☐ English ☐ Other:			Pharmacy:	Location:
Are you a Veteran or the family member of a Veteran: ☐ Yes ☐ No				
Home phone #: ( ) -		Cell phone #: ( ) -		SSN: - -
Street address:				Apt #:
City:		State:		ZIP Code:
Email address:				
Occupation:	Employer:			Emp phone #: ( ) -
Was this an Injury: ☐ Yes ☐ No	If yes, which: ☐ Auto ☐ Worker's Comp ☐ Other:			

IF YOU ANSWERED YES PLEASE COMPLETE THE WORKER'S COMPENSATION OR AUTO ACCIDENT PATIENT REGISTRATION FORM

HEALTH INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist

Primary Insurance:		
Policyholder's Name (as listed on insurance card):	Policyholder's Date of Birth: / /	Policyholder's SSN: - -
Insurance ID#:		Group#
Policyholder's Employer:		
Patient's relationship to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other		

Secondary Insurance (if applicable):		
Policyholder's Name (as listed on insurance card):	Policyholder's Date of Birth: : / /	Policyholder's SSN: - -
Policyholder's Employer:		
Insurance ID#:		Group#:
Patient's relationship to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other		
Responsible party name:		

IN CASE OF EMERGENCY

Name of friend or relative (not living at same address):	
Relationship to patient:	Phone #: ( )

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.
(You may list spouse, children, relatives, etc.)

Name(s): Relationship to patient:

PRIVACY STATEMENT:

We protect our patient's information and the records that we have about their health and the services received in our office. We must have your written, signed consent in order to disclose your health information for the purposes of your treatment, the payment of your bills, appointment reminders etc. I have received a copy of the Privacy Notice. (HIPAA - 164.520) Effective 04/14/2003. I f we refer our patients to another provider or specialist, we may need to share your medical information with them. Your privacy is protected as only minimum information is shared.

Signature: _____ Date: _____

Please provide a preferred telephone number where you want to receive calls. : ( ) -

May we leave a confidential message about your care on your answering machine / voice mail? ☐ Yes ☐ No

- Financial Responsibility: The above information is true to the best of my knowledge. I authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign the doctor all payments for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by insurance and that I will pay any co-pays on the date of service unless other arrangements are made.

Responsible Party Signature: _____ Date: _____

- Medicare Authorization: I request that payment of authorized Medicare benefits be made to the Genesys Integrated Group Practice on my behalf. I authorize the holder of my medical information to release to the HCFA and their agents any information needed to determine these benefits for related services. I understand that HCFA is the government Medicare agency.

Medicare Beneficiary Signature: _____ Medicare #: _____ Date: _____

Review of Systems/Medical History Update

Patient Name: _____ **Date:** _____

DO YOU CURRENTLY (OR HAVE YOU EVER EXPERIENCED) ANY OF THESE SYMPTOMS? IF YES PLEASE CHECK BOX

General, constitutional
- ☐ Good general health lately
- ☐ Recent weight loss
- ☐ Fever
- ☐ Fatigue

Eyes
- ☐ Eye disease/injury
- ☐ Wear glasses or contacts
- ☐ Blurred or double vision
- ☐ Glaucoma

Ears, Nose, Mouth, Throat
- ☐ Hearing loss/ringing
- ☐ Earaches or drainage
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Bad breath or bad taste
- ☐ Swollen glands in neck

Heart and Cardiovascular
- ☐ Heart trouble
- ☐ Chest pain
- ☐ A-Fib
- ☐ Swelling of feet ankles, hands

Respiratory
- ☐ Frequent cough
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Asthma or wheezing

Gastrointestinal
- ☐ Loss of appetite
- ☐ Change in bowel movement
- ☐ Nausea or vomiting
- ☐ Abdominal pain
- ☐ Blood in stool

Genitourinary
- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Kidney stones

Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness / swelling
- ☐ Weakness of muscle / joints
- ☐ Back pain
- ☐ Cold extremities hands / feet
- ☐ Difficulty walking

Skin
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in nail or hair
- ☐ Dry skin

Psychological
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia

Neurological
- ☐ Frequent or recurrent headaches
- ☐ Light headed or dizzy
- ☐ Convulsions / seizures
- ☐ Numbness / tingling sensations
- ☐ Tremors
- ☐ Paralysis
- ☐ Stroke / slurred speech
- ☐ Head injury
- ☐ Memory loss or confusion

Endocrine
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Liver/Renal failure
  - Days of dialysis _____
  - Time _____ AM / PM
  - Location _____
- ☐ Excessive thirst / urination
- ☐ Heat / cold intolerance

Hematological / Lymphatic
- ☐ Slow to heal after cuts
- ☐ Bleeding / bruising tendency
- ☐ Phlebitis
- ☐ Transfusions
- ☐ Cancer _____

Social History
Smoker ☐ Never ☐ Moderate ☐ Daily
Alcohol ☐ Never ☐ Moderate ☐ Daily
Street Drugs ☐ Never ☐ Moderate ☐ Daily
Type _____

Procedure / Surgery	Year

Medications	Dosage

Family Medical History

	Age	Medical problem
Father		
Mother		
Siblings		
Children		

Drug Allergies
_____
_____
_____
_____
_____
_____

MD Review: _____

Date: _____