



VASCULAR INSTITUTE OF ARIZONA

Patient Registration Form

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____ Alternate Phone Number (cell or work): _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: M F Social Security Number: _____

Marital Status: Married Single Divorced Widowed

Patient's Employer: _____

Employment Status: Full time Part time Unemployed
 Retired Student Other: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____

Date of Birth: _____

His or Her Employer: _____ Work Phone Number: _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above-named patient.

Name(s): _____ Relationship to Patient: _____

Patient / Parent or Guardian Signature: _____ Date: _____

HEALTH HISTORY

Personal Information

Date: _____

Patient Name: _____ Birth Date: ____/____/____ Age: ____

Occupation _____ Marital Status: _____ Name of Partner/Spouse: _____

Race: Asian Black or African American Native American White / Caucasian

Other: _____

Ethnicity: Do you identify with an Ethnic origin? If yes, please note: _____

Number of children: _____

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor: _____

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): _____

Preferred **Pharmacy:** _____

If **YOU** have any of the following, please circle and indicate when applicable:

ADD/ADHD	<input type="checkbox"/>	Type 1 or 2 Diabetes	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>
Allergies/Hay Fever	<input type="checkbox"/>	Gynecological Disease	<input type="checkbox"/>	Stomach/Colon Disease	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>
Anxiety/Depression	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Other:	
Cancer, Type/s		Neurological Disease	<input type="checkbox"/>	_____	
_____		Osteopenia/Osteoporosis		_____	
_____		_____			

Please list any **SURGERIES** you have had and include the month/year:

Social Information

Tobacco Use: Do you smoke? ____ If so, how many cigarettes/cigars per day: ____ No. of years smoking: ____ Do you chew tobacco? ____ Have you thought about quitting? ____ Have you quit before? ____ How long? ____

Alcohol Use: Do you drink alcohol? ____ If so, what type? _____ How many in 1 week? ____

Drug Use: Any history of illegal drug use? ____ If so, what type/s? _____ When? _____

Do you **exercise**? ____ What activities do you do, and how often in 1 week? _____

Are you on any special **diet**? ____ If so, what? _____

Do you consume any **caffeinated** products? ____ If so, what and how much per day? _____

Have you recently noticed an increase in sadness or gloominess? ____

Have you lost interest in enjoyable activities? ____

Do you have a living will? ____ If yes, please provide us a copy.

Authorization for Claims Payment and Reviews

1. Assignment and Coordination of Insurance Benefits - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Vascular Institute of Arizona (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to Vascular Institute of Arizona (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. Unauthorized, Non-Covered, or Out of Plan Services - I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to Vascular Institute of Arizona for this admission or any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge. In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. For Medicare Recipients Only - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

4. Residents, Interns or Medical Students- I understand residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of Vascular Institute of Arizona education programs.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Vascular Institute of Arizona. *I understand and agree this document will remain in effect for all future outpatient or physician office visits to Vascular Institute of Arizona, unless specifically rescinded in writing by me.*

Patient Signature: _____ Date: _____

Relationship to Patient: _____

