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: _____

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: _____

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

Please list any **SURGERIES/ PROCEDURES** 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?_____

_____

Family History:

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

Patient Financial Responsibility Agreement

Responsibility. I understand I am ultimately responsible for all payment obligations arising out of my treatment and care and I guarantee payment for these services. I am responsible for deductibles, co-payments, co-insurance or any other patient responsibility amount indicated by my insurance carrier or for any services not covered by my insurance. I agree to be fully responsible for payment to Vascular Institute of Arizona for any service determined by my insurance plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Network/Plan 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. If I receive any insurance payment for services rendered by Vascular Institute of Arizona, I will sign over the check(s) to Vascular Institute of Arizona with the Explanation of Benefits within (5) business days of receipt of the check. If my check payment is returned or declined for any reason, my account will be charged a surcharge of $35.00 in addition to any costs assessed or charged by the bank.

Insurance Policy. It is my responsibility for knowing and understanding my insurance policy, both the coverage benefits and policy limitations. I understand I am personally responsible for payment when: (i) my health plan requires prior authorization/referral by a primary care physician (PCP) before receiving services, and I have not obtained such an authorization or referral; (ii) I receive services in excess of the authorization/referral; (iii) my health plan determines the services I received are not medically necessary and/or not covered by my insurance plan; (iv) my coverage has lapsed/expired at the time services are rendered; (v) I have chosen to utilize my out-of-network benefits; or (vi) I have chosen not to use my health plan coverage for services I receive.

Non-Payment on Account. Should collection proceedings or legal action become necessary to collect my overdue or delinquent account, I understand Vascular Institute of Arizona has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. I am responsible for all costs of collection including, but not limited to all fees incurred in the collection process; and I acknowledge that if my account is referred to a collection agency, or when the past due status is reported to a credit reporting agency, it may have an adverse effect on my credit history. Once my account my account is placed with a collection agency, I am responsible for communicating with their offices for payment. I may lose my ability to be seen at Vascular Institute of Arizona as a result of my account being sent to a collection agency.

By Signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered an accept the above conditions and terms and 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 that in the event my account must be placed with a collection agency to obtain payment, I will pay the reasonable 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: _____