REGISTRATION FORMS

Please Print Legibly

I.PATIENT INFORMATION:

Last Name: _____ First Name_____ Sex___M_____F Date of Birth ____/____/_____

Social Security #_____-_____-_____Marital Status (S) (M) (W) (D) Home Phone #_____

Preferred Language_____ Email Address_____ Cellular Phone#_____

Address _____

Emergency Contact _____ Telephone Number _____ Relationship _____

II. Referring Physician:

Physician Name _____ Telephone Number _____Fax_____

Address _____

III. PRIMARY CARE PHYSICIAN:

Physician Name _____ Telephone Number _____Fax_____

Address _____

IV. EMPLOYER INFORMATION:

Name of Employer _____ Work Number_____ext._____

Address _____

V. SPOUSE'S INFORMATION:

Spouse's Name_____ Sex____ M_____F Date of Birth _____/_____/_____

Spouse's Social Security # _____-_____-_____Spouse Employed by_____

Spouse's Employer Address_____

VI. INSURANCE INFORMATION: (Please provide insurance cards for verification)

Primary Insurance Coverage_____Relationship to Subscriber _____

Subscriber's Name _____Subscriber's Date of Birth _____/_____/_____

Subscriber's Social Security Number _____-_____-_____

Insurance ID Number _____ Group Number _____ Plan Number _____

Claims Address _____

VII. Secondary Insurance Coverage _____Relationship to Subscriber _____

Subscriber's Name _____Subscriber's Date of Birth _____/_____/_____

Subscriber's Social Security Number _____-_____-_____

Insurance ID Number _____ Group Number _____ Plan Number _____

Claims Address _____

AUTHORIZATION FOR RELEASE OF INFORMATION BY DR.SAFA, MD, PC or DR.PATETSIOS, MD.

I hereby authorize and direct the above name surgical practice , having treated me , to release to government agencies, insurance carriers, or others who are financially liable for my medical care , all information needed to substantiate payment for such medical care and to permit representatives therefore to examine and make copies of all records relating to such care and treatment.

Signature of patient or Authorized Representative _____Date _____/_____/_____

I hereby assign, transfer , and set over to the above named faculty practice sufficient monies and/ or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent in said practice.

Signature of patient or Authorized Representative _____Date _____/_____/_____

PLEASE TURN OVER TO COMPLETE

Patient Name: _____ **Age:** _____ **Date:** _____/_____/_____
Referring Doctor: _____ **Primary care doctor:** _____

Reason for your visit today:

_____

_____

Medical History (Please check what applies):

	Heart Disease		Diabetes		Peripheral Vascular Disease
	Heart Attack		High Blood Pressure		Leg Ulcers
	Heart Valve Replacement		Stroke		Tendency to bleed
	Increased Cholesterol		Kidney / bladder problems		Other_____

Have you ever had any surgery? ___Yes/___No
If yes, please explain, including dates:

1.	4.
2.	5.
3.	6.

Have you ever had a blood clot? ___Yes/___No
For female patients: Have you ever been pregnant? ___Yes/___No, Currently Breast Feeding? ___Yes/ ___No

Do you experience any of the following symptoms? (Please check what applies):

	Aching/Pain in legs		Swollen Ankles		Leg pain with exertion
	Heaviness		Shortness of breath		Ulcerations/Sores on Legs
	Tiredness/Fatigue		Leg Cramps		Bleeding from Veins
	Itching/Burning		Tingling / numbness		Vision Loss
	Throbbing		Restless Legs		Weakness

___Other, Please List _____

Do you experience pain in your legs? ___One ___Both
Do you elevate your legs to relieve discomfort? ___Yes/___No, How often?_____
Do you wear support hose prescribed by a doctor? ___Yes/___No
Do you do a lot of standing during the day? ___Yes/___No
Have you ever had any tests done on your circulation? ___Yes/___No
If yes, when and what type of test _____

Allergies (Please list any or if none, write NONE):

Medications taken regularly that require a prescription:

1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

Over the counter medications, herbs, etc. _____

Does anyone in your family have any of the following conditions and if so, who?
Circulation problems _____ Varicose veins _____ Diabetes _____
Heart disease _____ High blood pressure _____
Other known heredity/genetic diseases_____

Smoker? _____ Yes _____No If yes, how many packs/day? _____ If Quit, how long ago? _____

AUTHORIZATION FOR RELEASE OF INFORMATION
AND
ASSIGNMENT OF BENEFITS
FOR MEDICARE PATIENTS

PATIENTS NAME_____ **MEDICARE #**_____

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to ***Peter Patetsios MD*** for any services furnished to me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits payable for related services."

I understand that information will be released to the billing department of the physician and/or practice

I understand that my information, under certain circumstances may be released for one of the following reasons:

- Other health care professionals in order to coordinate my care or treatment
- Insurance adjuster if my claims is a work or motor vehicle injury
- Employer, if my claim is related to a work injury
- Attorney, if my claims are in a litigation process
- Health insurance carrier, for chart audit reason, and for claim payment

I understand that my physician and/or his staff and the billing office will not release any information to myself or family members over the phone without verification of my identity in order to comply with privacy regulations. I also understand that my physician and his/her staff and the billing office will maintain the utmost respect for privacy. However, I also understand that there are physical constraints such as noise and the ability for others to overhear information, and other errors that may occur, which may cause inadvertent dissemination of information, as well as the potential for confidential information to be disclosed after it has been provided to others from the clinical billing office.

By my signature, I state that I have read, understand, and agree to this Authorization and Release.

_____ _____

Patient or Guardian Signature Witness

_____ _____

Date Date

A 2ND SIGNATURE IS REQUIRED FOR YOUR SUPPLEMENTAL INSURANCE

I request that payment of authorized Medigap benefits be made either to me or on my behalf to my provider of service and/or supplier for any services furnished to me by that the provider of service and/or supplier. I authorize any holder of Medicare information about me to release to my secondary insurer, named above, any information needed to determine these benefits payable for related services.

_____ _____

Signature Patient or Guardian Date

PATIENT AGREEMENT FOR FINANCIAL RESPONSIBILITY

I, _____, understand that the physician's billing staff will file all claims for services rendered to my insurance carrier, if applicable. I also understand that if I am not insured, I must pay my balance for services rendered by my provider. I acknowledge that I am responsible for any balances that may be due to the physician because of:Co-insurance or co-pay amounts, yearly deductible amounts, non-covered services, out of Network charges, terminated coverage, exhausted auto benefits, denied Worker's Compensation claim, no insurance coverage, no referral obtained from Primary Physician, failure to respond to insurance carrier correspondence, failure to respond to coordination of benefits inquiry and cosmetic surgery.

I understand that I will receive a statement for any balance due, after my carrier has processed the claim. I understand and am agreeable that the balance of my statement will be paid in full to the physician within 30 days. If I am unable to pay the entire amount (applies to amounts of $150.00 or more), I am responsible to immediately, upon receipt of statement, call the billing office @ 800-322-4606, to arrange a monthly payment plan, for no less than $50.00 per month.

I understand that failure to pay my balance or arrange payments and follow that payment agreement may result in Collection Agency action.

_____ _____

Signature of patient/guardian/responsible party Date (mm/dd/yy)

Authorization of Use and Disclosure of Protected Health Information

I, _____, authorize this medical practice ***Peter Patetsios, MD*** to disclosure, the information listed, to the individuals listed below.

I understand that information disclosed to this (these) individual(s) may re-disclose information inadvertently to other parties. The privacy of this information may not be protected under the federal privacy regulations. This practice does not take responsibility for any disclosure made by the individual(s) listed below.

You may revoke or terminate this authorization by submitting your request in writing. Please contact the Privacy Officer if you should wish to terminate or change this authorization at a later date.

ALL of my Protected Health Information may be given/released to:

- ☐ Only myself
- ☐ Spouse / significant other _____ (Name of person) _____ (date)
- ☐ Children _____ (Name of person) _____ (date)

  _____ (Name of person) _____ (date)

  _____ (Name of person) _____ (date)
- ☐ Other _____ (Relationship to patient) _____ (Name of person or organization) _____ (date)

  _____ (Relationship to patient) _____ (Name of person or organization) _____ (date)

_____
Patient Signature

_____
Date