PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name	Today's Date	Date of Birth	Sex	Age
Parent if Patient is a Minor				
Patient's Social Security Number				
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Home Telephone Number/cell #		Work Telephone Number		
Occupation		Employer's Name		
Employer's Address	City	State	Zip	
Spouse Name		Employer		
Primary Care Physician's Name		Would you like a copy of the results to go to this physician?		
Whom May We Thank for Referring You to Our Practice?				

NOTIFY IN CASE OF EMERGENCY

Name		Relationship		
Address	City	State	Zip	
Home Telephone		Work Telephone		
Nearest Relative (not living with your)				
Home Telephone		Work Telephone		

NOTICE OF PRIVACY PRACTICES:

I have been provided an opportunity to review the Notice of Privacy Practices (HIPPA).

Request a Copy _____No _____Yes

Signature: _____ Date: _____.

MEDICARE PATIENT (One-Time Authorization)

I request that payment of authorized Medicare benefits be made on my behalf to Vascular Diagnostic Center of Oak Ridge, Inc. for any services furnished to me by that provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE: _____ DATE: _____.

MEDIGAP ASSIGNMENT AUTHORIZATION:

I request that pay of authorized Medigap benefits be made on my behalf to Vascular Diagnostic Center of Oak Ridge, Inc. for any services furnished to me by that provider. I authorize any holder of medical information about me to be released to the Medigap Insurance Company any information needed to determine these benefits.

SIGNATURE: DATE:

Vascular Diagnostic Center

Vascular Medical History

Chart Number: _____

Patient's Name: _____ **Date:** _____

Are you a smoker? _____For How Long? _____How many packs per day? _____

If you currently do not smoke, have you smoked in the past? _____How long? _____

Are you allergic to latex? **No** _____ **Yes** _____

Do you have a history of any of the following? ***(If yes, please put when)***

Abdominal Pain after eating	No ___	Yes ___	When _____
Angina	No ___	Yes ___	When _____
Blood Clot (Deep Venous Thrombosis)	No ___	Yes ___	When _____
Chest Pain	No ___	Yes ___	When _____
Claudication (leg pain with exercise)	No ___	Yes ___	When _____
Congestive Heart Failure	No ___	Yes ___	When _____
Diabetes	No ___	Yes ___	When _____
Heart Attack	No ___	Yes ___	When _____
High Blood Pressure (hypertension)	No ___	Yes ___	When _____
High Cholestrol (hyperlipedemia)	No ___	Yes ___	When _____
Shortness of Breath	No ___	Yes ___	When _____
Slurred Speech	No ___	Yes ___	When _____
Stroke (CVA)	No ___	Yes ___	When _____
Tingling Sensations of Hands or Feet	No ___	Yes ___	When _____
Varicose Veins	No ___	Yes ___	When _____
Vision Problems only lasting a few minutes	No ___	Yes ___	When _____
Weakness of Hands or Feet	No ___	Yes ___	When _____

Are you currently taking any blood thinning medication or aspirin? _____

If yes, the name of the medication_____

How often?_____

If you would like a copy of this test to be forwarded to other physicians, please write these physicians down: _____

_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ❑ Home Telephone _____
  - ❑ O.K. to leave message with detailed information
  - ❑ Leave message with call-back number only
- ❑ Work Telephone _____
  - ❑ O.K. to leave message with detailed information
  - ❑ Leave message with call-back number only
- ❑ Written Communication
  - ❑ O.K. to mail to my home address
  - ❑ O.K. to mail to my work/office address
  - ❑ O.K to fax to this number
- ❑ Other _____

_____ Patient Signature

_____ Date

_____ Print Name

_____ Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitue an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

OFFICE USE ONLY

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclouse is authorized
(2) Type key: T=Treatment Records: P=Payment Information: O=Healthcare Operations
(3) Enter how disclosure was made F=Fax: P=Phone: E=Email:M=Mail: O=Other

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vdcor@aol.com
Phone 865.482.4028
Fax 865.481.3257

Record Release

I,_____, hereby authorize Vascular Diagnostic Center of Oak Ridge, Inc. (VDC) to release complete medical records to my physicians upon request.

Also, I hereby authorize my physician's office to furnish Vascular Diagnostic Center of Oak Ridge, Inc. (VDC) complete medical records upon request.

Sign Here _____ Date _____

Relationship to Patient: _____

Witness(sign) _____(print)_____