Allegheny Vein & Vascular
900 Chestnut St. Ext., Suite A, Bradford, PA 16701
Phone: 814.368.8490 Fax: 814.368.8041

New Patient Paperwork 1 of 8

Patient Name:_____
(last) (first) (middle)

Chief Complaint:_____

Name of referring physician: _____ **Phone#**_____

Name of Primary Care Physician(PCP):_____**Phone#**_____

Other physicians currently seeing:_____ **Phone#**_____

_____ **Phone#**_____

Name of Pharmacy:_____ **Phone#**_____

Do you have a medical power of attorney? YES / NO **Living will?** YES / NO

Do you have advanced medical directives? DNR - YES / NO **DNI -** YES / NO

Allergies: (please list the allergy AND the reaction you have to it)

Medications: Please list all your medications, the dose of the medication, how often you take the medication, and why you take it. If needed continue on back of page:

Medication	Dose	Take it how many times a day?	Why do you take it?

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New Patient Paperwork

Patient Name:_____
(last) (first) (middle)

Have YOU ever had any of the following? Please circle appropriate:

Artery disease	Sleep apnea	Varicose veins
Heart attack	Seizure	Gastric ulcers
Heart failure	Kidney stones	Bleeding disorder
Pacemaker	Kidney failure	Blood clots
High blood pressure	Aneurysm	Psoriasis or Eczema
High cholesterol	Hyperthyroid	Gout
Stroke	Hypothyroid	Degenerative Disc disease
Diabetes	Prostate enlargement	Auto immune disorders
Gallstones	Hemorrhoids	Neurological disorders
Anemia	Osteoporosis	Asthma
Liver disease	Arthritis	COPD
Heartburn/reflux	Rheumatoid Arthritis	Emphysema
Migraines	Tendency to bleed/bruise	Pneumonia
Atrial Fibrillation		

Cancer, Type:_____
Other:_____

Vascular Surgeries:

Heart bypass _____	Varicose vein stripping _____
Lower extremity bypass _____	Varicose vein/radio frequency ablation _____
Carotid surgery _____	Varicose vein/cosmetic procedures _____
Stents/Angioplasty _____	Dialysis surgery _____

Past surgical history: (Please circle appropriate and enter year)

Cataract_____	Hysterectomy_____
Other Eye Surgery:_____	Neck_____
Ears_____	Prostate_____
Sinus/Nasal_____	C-Section_____
Tonsils/Adenoids_____	Vasectomy_____
Thyroid_____	Tubal ligation_____
Heart_____	Back_____
Stomach_____	Hip replacement_____
Gall bladder_____	Knee replacement_____
Appendix_____	Broken bone repair_____
Mastectomy_____	Inguinal Hernia_____
Pacemaker_____	Umbilical Hernia_____
Colonoscopy_____	Other Hernia_____
EGD_____	Other_____

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New Patient Paperwork

Patient Name:_____
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Social History:

Marital Status: (Please circle appropriate)
Divorced Married Separated Single Widowed

Diet: (Please circle appropriate)
Unrestricted Diabetic Renal Heart Healthy Other:_____

Exercise: (Please circle appropriate)
How many times per week?_____

Caffeine (Please circle appropriate)
Coffee Tea Soda - How many 8 oz servings per day?_____

Tobacco dependence: (Please circle appropriate)

☐ I have **never** used tobacco/nicotine

☐ **I currently use:**
Type: Cigarettes Chewing tobacco Alternative: Vaping / Patches / Gum
How long have you used?_____ How much per day?_____

☐ **I used to use tobacco/nicotine:**
Type: Cigarettes Chewing tobacco Alternative: Vaping / Patches / Gum
How long did you use? _____ What is the most you used in one day?_____
Quit date: _____

Alcohol: (Please circle appropriate)

☐ I do not drink alcohol

☐ **I currently drink alcohol:** (please circle type and amount)
Beer (8oz) Wine (4oz) Liquor/spirits (1oz)
How many servings per day?____ per week?____ per month?____

Have you ever used recreational drugs? Yes / No **What type:**_____
Do you currently use recreational drugs? Yes / No **What type:**_____

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Patient Name:_____
(last) (first) (middle)

FAMILY History (Have your Parents, Grandparents, Siblings, Children had any of the following):

Artery disease	Sleep apnea	Varicose veins
Heart attack	Seizure	Gastric ulcers
Heart failure	Kidney stones	Bleeding disorder
Pacemaker	Kidney failure	Blood clots
High blood pressure	Aneurysm	Psoriasis or Eczema
High cholesterol	Hyperthyroid	Gout
Stroke	Hypothyroid	Degenerative Disc disease
Diabetes	Prostate enlargement	Auto immune disorders
Gallstones	Hemorrhoids	Neurological disorders
Anemia	Osteoporosis	Asthma
Liver disease	Arthritis	COPD
Heartburn/reflux	Rheumatoid Arthritis	Emphysema
Migraines	Tendency to bleed/bruise	Pneumonia

Cancer,Type:_____
Other:_____

Preventative Care (have you ever had the following vaccines):

Flu Vaccine: YES / NO If yes, date of last dose: _____

Pneumonia Vaccine: YES / NO If yes, date of last dose: _____

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Patient Name:_____
(last) (first) (middle)

Do YOU CURRENTLY have any of the following? (Please circle appropriately)

General:
Changes in appetite
Chills or fever
Night sweats
Fatigue
Weight loss or weight gain
Excessive thirst or hunger

Vascular:
Chest pain or palpitations
Shortness of breath
Leg pain with walking
Cramping in legs or restless legs
Varicose veins or spider veins

HEENT:
Nose bleeds
Dry mouth or difficulty swallowing
Headaches or double vision
Lightheaded or dizziness

Respiratory:
Chronic cough or difficulty breathing
Coughing up blood
New shortness of breath

Gastrointestinal:
Abdominal pain or bowel changes
Diarrhea or bloody stools
Nausea or vomiting
Ulcers
Hemorrhoids

Genitourinary:
Urinary frequency / hesitancy
Urinary incontinence
Nighttime urination
Painful urination
Blood in urine

Musculoskeletal:
Joint pain or swelling
Joint redness
Muscle weakness or aches/pain

Skin:
Rash or nonhealing wounds
Dry or peeling skin
Psoriasis or Eczema

Neurologic
Stroke symptoms
Mini-stroke symptoms
New numbness or weakness
Loss of vision in one eye (sudden onset)

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Patient Name:_____
(last) (first) (middle)

SS#_____

Address
Address line 1:_____

Address line 2:_____

City:_____ State:_____ Zip:_____

Home Phone #_____ Work #_____

Cell #_____

Email: _____

Place of employment:_____

Emergency Contact #1: _____ Relationship: _____
Phone #: _____

Emergency Contact #2: _____ Relationship: _____
Phone #: _____

Primary insurance:_____ ID#_____

Group # _____ Plan # _____

Secondary insurance:_____ ID#_____

Group # _____ Plan # _____

How did you hear about us? (circle all that apply)
Newspaper | TV | Yellow pages | Family/friend | Internet | Facebook | Twitter | Instagram

Radio: Mega Rock 105.5/100.5 FM The Hero 100.1 FM - WBRR
1490 AM / B107.5 FM - WESB The Hound 97.5 FM - WDDH
B94 93.9 FM - WKBI News Talk 1400 AM / 94.5 FM - WKBI

Other: _____

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New Patient Paperwork

Patient Name:_____
(last) (first) (middle)
Date of birth: _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR INSURANCE be made either to me or on my behalf to my physician practice for any services furnished me by physician or supplier. 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 payable for related services.

_____ **Date:**_____
Patient or Authorized Person's Signature/relationship

I AUTHORIZE THE RELEASE OF ANY INFORMATION including the diagnosis and the records or any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Medicare/Medical Assistance Patients: I hereby certify that the information given by me in applying for payment under Title XVII (Medicare) and Title XIX (Medical Assistance) of the Social Security Act is correct. Release of all records requried to act on this request is hereby authorized.

_____ **Date:**_____
Patient or Authorized Person's Signature/relationship

PERMISSION FOR DIAGNOSTIC PROCEDURES/TREATMENT:
I hereby give permission to the staff and personnel at my physician's practice to perform such diagnostic studies and/or to render treatment.

_____ **Date:**_____
Patient or Authorized Person's Signature/relationship

_____ **Date:**_____
Witness (AVV Employee)

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New Patient Paperwork 8 of 8

Allegheny Vein & Vascular Disclosure Opt Out Form and Receipt of Privacy Practices

Patient Name:_____
(last) (first) (middle)
Date of birth: _____

Disclosure Opt Out Form and Acknowledgement of Receipt of Notice of Privacy Practices
This form provides you with the the opportunity to opt out of having your health information dislcosed to individuals involved in your care. You must return this form to us so we know your wishes in regards to such disclosure. If we do not receive this form we will assume your wishes are to release the information under **these** circumstances:

Disclosures to Persons Involved in Your Care
This organization may disclose personal health information about you to your family, close personal friends, or any person that you identify, as long as the information disclosed to these individuals is relevant to their involvement in your care or for payment of your care. This Organization also may notify a family member or another person who is responsible for your care of your location and general health condition. Please initial one of the following to indicate your choice regarding such disclosures:

___ I *DO NOT* object to my personal health information being disclosed to a family member, friend or another individual involved in my care.

____ I *DO* object to my personal health information being dislcosed to a family member, friend or another individual involved in my care.

____ I DO NOT WANT MY PERSONAL INFORMATION DISCLOSED *TO THE FOLLOWING INDIVIDUALS*:

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that this Notice may be changed at any time. I may obtain the current copy of the Notice by calling 814.368.8490 or requesting one from the Allegheny Vein & Vascular office personnel at 900 Chestnut St Ext, Suite A , Bradford, PA 16701.

_____ **Date:**_____
Patient

* As the representative of the above named individual, I acknowledge receipt of the Notice on his or her behalf.

_____ **Date:**_____
*** Authorized Person's Signature/relationship**

_____ **Date:**_____