M. Usman Nasir Khan M.D.
F.A.C.S., F.S.V.S., F.S.C.A.I
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10 Industrial Way East. Suite 103
Eatontown, NJ 07724
Phone: 732. 641.VEIN(8346)
Fax: 848.208.3445
www.vvcnj.com

PATIENT REGISTRATION

Patient Name:(LAST)_____ (FIRST)_____ (MIDDLE)_____

Address _____ City_____State _____Zip _____

Date of Birth: _____ Age_____ Sex: F M O Marital Status: S M D W Language:_____

Prefered Phone Number_____ ◯Cell ◯Home ◯Work

Email: _____ Occupation: _____

Race:
- ◯ American Indian/Alaska Native
- ◯Native Hawaiian/Other Pacific Islander
- ◯Asian
- ◯White
- ◯Black/African
- ◯Choose not to answer

Ethnicity
- ◯Hispanic/Latino
- ◯Not Hispanic/Latino
- ◯Choose not to answer

Primary Care Physician: _____

Address:_____ Phone:_____

Referring Physician:_____ ◯ Same as Primary ◯ Self-Referred

Address:_____ Phone:_____

Pharmacy Name:_____ Pharmacy Phone No.:_____

Pharmacy Adress: _____

Emergency Contact Name:_____ Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ Effective Date:_____

Policy/ID Number: _____ Group: _____

Subscriber's Name: _____ D.O.B.:_____

Relation to Subscriber(s):_____Subscriber(s) Employer:_____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____ Effective Date:_____

Policy/ID Number: _____ Group: _____

Subscriber's Name: _____ D.O.B.:_____

Relation to Subscriber(s):_____Subscriber(s) Employer:_____

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CONSENT FOR TREATMENT

I acknowledge that I have elected on my own behalf or on behalf of my dependent to receive medical services that may or may not be covered by my health plan or any number of reasons. Consent to have a medication list received and reviewed.

I understand and acknowledge that I am financially responsible for, and therefore shall pay for, all services rendered to me or my dependent that is not paid or contractually adjusted by my insurance, in whole or in part, by my health plan for any reason whatsoever.

RELEASE OF INFORMATION
I authorize the release of all information necessary to process my insurance claims and pertinent to my medical care. This release will remain in effect until revoked by me in writing. A photocopy of this release is to be considered as valid as the original.

ASSIGNMENT OF BENEFITS
I assign all medical and/or surgical benefits including major medical benefits to which I am entitled, including Medicare, BCBS, HMO plans, and commercial insurance to the Vascular & Vein Center of New Jersey. This assignment will remain in effect until revoked by me in writing. I hereby authorize the above to release information to secure payment on my behalf.

I understand that I am financially responsible for all charges. I have read this information and understand it.

Patient Name:_____D.O.B:_____

Signature:_____

(If the patient is a minor)
Signature of Parent/Guardian:_____Date: _____

APPOINTMENT CANCELLATION AND “NO SHOW” POLICY

If you need to cancel an appointment, you must call the office at least **24HRS** in advance of the scheduled appointment time and let our team know.

If you do not cancel at least 24HRS in advance, we will mark you as a “no-show.” No fee will be charged to your account for your first “no-show.” However, for every following “no show”, a $25 fee may be charged to your account. You will be responsible for payment.

UNLESS THERE ARE EXTENUATING CIRCUMSTANCES, THESE POLICIES WILL REMAIN IN EFFECT.

SIGNATURE _____ DATE: _____

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Acknowledgment of Receipt of Notice and Approval of Privacy Practices

I, _____ hereby acknowledge that I have received the corresponding HIPAA Notice of Privacy Practices. I also further acknowledge and approve the uses and disclosures of my PHI as described in the HIPAA Notice of Privacy Practices

Patient Contact Authorization

I, _____, authorized and give permission to Vascular & Vein Center of New Jersey, and any practice staff members, to leave messages regarding my medical information on the following telephone(s):

Home:_____ Cell:_____

I authorized and permit Vascular & Vein Center of New Jersey, and any practice staff members, to speak with the following people regarding my medical status and/or treatment:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

_____ _____

Date **Signature of Patient or Representative**

PERMISSION TO RECEIVE PRERECORDED MESSAGES AND/OR TEXT MESSAGES

As a service to our patients, we provide courtesy appointment reminder calls and text messages when possible. We also may place other important calls and send text messages using a prerecorded or automated message. To authorize receiving calls and messages, please fill out the information below and provide the phone number where you wish to receive these messages.

Important note: By providing your cell phone number below, you consent to receive appointment reminder calls, important calls, and/or text messages on your cell phone. If you would like us to utilize a different number, please provide that number below instead of your cell phone number.

This authorization permits us to leave messages, calls, or texts on the phone provided below. If you provide your cell phone number, you will receive automated or prerecorded messages on your cell phone. We are required by law to advise you of this.

You do not need to sign this authorization. However, if you do not sign this authorization, we will not be able to provide you with courtesy reminder calls, text messages, or other important calls.

Patient
Name:_____Signature:_____

(If the patient is a minor)
Signature of Parent/Guardian:_____Date: _____

Phone No. authorized by the patient to receive calls and messages as set forth above:

Cell:_____ Home:_____Other: _____

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MEDICAL RECORD RELEASE AUTHORIZATION

PATIENT INFORMATION: I give permission to release the health information of:

Patient Name:_____ D.O.B.:_____

Address _____ (City/State) _____ (Zip)_____

RELEASE INFORMATION FORM:

_____
(List applicable facility(s) and/or practice(s))

_____
(Phone No.)(Fax No.)

RELEASE INFORMATION TO:

_____
(List applicable facility(s) and/or practice(s))

_____
(Street Address or P.O. Box, City, State, Zip Code)

_____
(Phone No.)(Fax No.)

Signature:_____Print Name: _____

Date:_____ Relationship to patient: _____

INITIAL EVALUATION

Name: _____ Appt Date _____/_____/_____
Last First MI

Height: _____ Weight:_____ Age:_____ D.O.B. _____/_____/_____

Reason for your visit today:_____

How long has this issue bothered you: _____ Details:

PAST MEDICAL HISTORY OF HOSPITALIZATIONS AND OPERATIONS

Surgery or Reason for Hospitalization	Hospital	Year	Doctor

Primary Care Physician Name:	Referring Physician Name:
Phone:	Phone:

Have you ever suffered from:

☐ Cancer	☐ Diabetes	☐ High Blood Pressure	☐ Hay Fever	☐ Hives (or other skin eruptions)
☐ Asthma	☐ Stroke	☐ Heart Problems	☐ Kidney Failure	☐ Other (please write below)
☐ Lung Problems	☐ Heart Conditions	☐ Bleeding Disorder	☐ High Cholesterol	_____
☐ Pneumonia	☐ Heart Attack	☐ Rheumatic Fever		

Do you have allergies? No ☐ Yes ☐ To What: _____
Explain Reaction:

Have you ever had a bad reaction to

☐ Penicillin	☐ Sleeping Pills	☐ Aspirin	☐ Local Anesthetic
☐ Sulfa	☐ Novocaine	☐ Kidney or X-ray Tests Using Dye or Contrast	
☐ Nome of the above			

Do you have a known drug-resistant organism? ☐ No ☐ Yes ☐ Don't know
☐ MRSA ☐ VRE ☐ Unknown

Have you ever smoked cigarettes regularly? ☐ No ☐ Yes
How many packs per day? _____ For how many years? _____
Do you still smoke? ☐ No ☐ Yes If No, When did you quit? _____

How much alcohol do you consume daily? _____
How much alcohol did you consume daily in the past?

Have you ever taken recreational drugs? ☐ No ☐ Yes
When? _____ Type:_____ Frequency: _____

For Office Use Only
HISTORY OF PRESENT ILLNESS

1)
2)
3)
4)

Location, duration, timing, quality, severity, context, modifying factors, associated sign and symptoms or status of 3 chronic conditions.

☐ Previously ordered diagnostic studies and medical records were reviewed

CURRENT LIST OF MEDICATIONS

NAME OF MEDICATION	DOSE	TAKEN HOW OFTEN

Family History

Father: Living? ☐ No ☐ Yes Age: _____
If deceased, at what age? _____
Cause of Death: _____
Current Health Status: _____
Illness or infirmity: _____

Mother: Living? ☐ No ☐ Yes Age: _____
If deceased, at what age? _____
Cause of Death: _____
Current Health Status: _____
Illness or infirmity: _____

Has anyone in your family ever had:
☐ Trouble similar to yous ☐ Heart Disease
☐ Allergic Condition ☐ Mental/Nervous Disorder
☐ Diabetes/High Glucose ☐ Bleeding Disorder
☐ Cancer: _____ Are you a bleeder?
☐ No ☐ Yes

SIBLINGS:_____
Total Number of siblings LIVING: _____
Important Illnesses: _____
Total number of siblings DECEASED: _____
List sex, age, and cause of death:
_____

SOCIAL HISTORY

☐ Married ☐ Single ☐ Widowed ☐ Significant Other Number of Children:_____
Who do you live with: _____
Occupation:

REVIEW OF SYMPTOMS

EYES	☐ Nearsighted	☐ Farsighted	☐ Glasses	☐ Double Vision	☐ Cataracs	☐ Glaucoma
	☐ No Problems	☐ Other:				
EAR, NOSE, MOUTH & THROAT	☐ Hearing Loss	☐ Hearing Aids	☐ Dentures	☐ Nosebleeds	☐ Hoarseness	
	☐ Bleeding from gums	☐ No Problems	☐ Other:			
CARDIOVASCULAR	☐ Chest Pain	☐ Palpitations	☐ High Blood Pressure	☐ Heart Murmur	☐ Ankle Swelling	☐ Leg Cramps
	☐ Leg Pain with Walking	☐ Shortness of Breath with exercise		☐ No Problems	☐ Other:	
LUNGS	☐ Cough	☐ Blood in Sputum	☐ Increase Sputum	☐ Shortness of breath		☐ Wheezing
	☐ No problems	☐ Other:				
GASTROINTESTINAL	☐ Recent Weight Loss	☐ Recent Weight Gain		☐ Diarrhea	☐ Decreased Appetite	☐ Nausea
	☐ Vomiting	☐ Constipation	☐ Blood in Stool	☐ Black Stool	☐ Regular Enemas	☐ Heartburn
	☐ Ulcers	☐ Jaundice	☐ No Problem	☐ Other		
GENITOURINARY	☐ Frequent Urination	☐ Burning on Urination		☐ Kidney/Bladder Stones		
	☐ Blood in Urine	☐ Difficulty Urinating		How often do you wake up at night to urinate? _____		
	☐ No Problems	☐ Other				
Women Only	☐ Abnormal periods	☐ Vaginal Bleeding	☐ Loss of urine when sneezing/coughing		☐ No Problem	
	☐ Other:					
MUSCULOSKELETAL	☐ Muscle Weakness	☐ Pain in joints or bones		☐ Limited Motion	☐ Joint Swelling	☐ Arthritis
	☐ No Problem	☐ Other:				
SKIN	☐ Sores	☐ Bleeding	☐ Rashes	☐ No Problems	☐ Other:	
NEUROLOGIC	☐ Headaches	☐ Fainting Spells	☐ Numbness	☐ Weakness	☐ Seizures	☐ Dizzy Spells
	☐ Temporary Blindness	☐ Loss of Speech	☐ No Problem	☐ Other		
PSYCHOLOGICAL	☐ Treatment of Depression	☐ Anxiety	☐ Hospitalization of Mental treatment	☐ No Problems	☐ Other	
ENDOCRINE	☐ Diabetes	☐ Thyroid Condition	☐ Gout	☐ No Problems	☐ Other	
HEMATOLOGIC	☐ Anemia	☐ Unusual Bleeding	☐ No Problem	☐ Other:		

Please include any other information you consider important: