www.cvm-usa.com

Corporate:
7474 Greenway Center Drive
Suite 650
Greenbelt, MD 20770
T 301-982-2000
F 301-982-2001

Clinical Offices:

Annapolis
108 Forbes Street, 2nd floor
Annapolis, MD 21401
T 410-626-1696
F 410-626-1697

Catonsville
1001 Pine Heights Avenue
Suite 202
Baltimore, MD 21229

Fairfax
8316 Arlington Blvd,
Ste 515
Fairfax, VA 22031

Greenbelt
7300 Hanover Drive,
Suite 104
Greenbelt, MD 20770
T 301-486-4690
F 301-441-8809

Prince Frederick
205 Steeple Chase Drive,
Suite 302
Prince Frederick, MD 20678
T 410-535-3945
F 410-535-1865

Silver Spring
831 University Boulevard East,
Suite 25
Silver Spring, MD 20903

Glen Burnie
1600 Crain Highway South,
Suite 409
Glen Burnie, MD 21061
T 410-590-1800
F 410-590-1801

Waldorf
12107 Old Line Center
Waldorf, MD 20602

New Patient Instructions – Center for Vascular Medicine

This information is to assist you in preparing for your initial appointment with us at CVM. Please complete the following documents prior to your visit and bring them with you. This will help expedite the registration process.

1. **Patient Information Form- this includes your insurance information for us to register you with our practice.**
2. **Medical Information Form- this form is to explain your previous medical history. It includes your medication and allergy list.**
3. **Consent for Disclosure of Protected Health Information- We will only share information with other physicians that have reasons to know for medical treatment unless otherwise instructed by patient.**

Most importantly, when you come for your visit, please be sure to bring the following documents as we need copies of them for our records.

1. **A photo ID such as a Driver's License, State ID, Military ID, etc.**
2. **Your current insurance cards**
3. **Your referral slip from your Primary Care Physician (if required by your insurance plan).**

If you have any questions or need assistance regarding the above information, please feel free to contact us at any time and we would be glad to assist you.

Your appointment is on:_____at:_____Office:_____

CENTER FOR Vascular Medicine

PATIENT DEMOGRAPHICS

A. PATIENT INFORMATION					
Last Name:	**First Name:**			**Middle Initial**	**Date of Birth**
Age	**Sex** **Male / Female**	**Marital Status**	**ETHNICITY**	**Preferred Language** **ENGLISH / SPANISH / OTHER: _____**	
Address:		**Apt #**	**City:**		**State:**
Zip Code:	**County:**		**Email address:**		
Please check the Contact of Preference: ☐ **Home Phone #** ☐ **Cell Phone#** ☐ **Work phone #** ☐ **Alternate Phone #** ☐ **Tex Messages**					
Home Phone Number:	**Cellular Phone Number:**		**Work Phone Number:**		**Alternate Phone Number:**
Emergency Contact Phone Number:	**Name of Person to Contact in Case of an Emergency**		**Relation:**		
Name of Referring Physician (if different from PCP)			**Referring Physician's Address, Phone, Fax #**		
Name of Primary Care Physician (PCP)			**Primary Care Physician's Address, Phone, Fax#**		
Name of a Different doctor you might want your records to be sent and Faxed to:					
B. EMPLOYER INFORMATION					
Patient's Employer	**Address:**			**Phone:**	
C. PRIMARY INSURANCE Must complete ***SUBSCRIBER*** and ***SUBSCRIBER DATE OF BIRTH*** for accurate billing:					
Insurance Name:	**Policy Holder Name: (if other than self)**		**Policy Holder DOB:**	**Relationship to Patient:**	
Policy Number:	**Group Number:**	**Copayment Amount:**	**Policy Holder Place of Employment:**		
D. SECONDARY INSURANCE (If applicable)					
Insurance Name:	**Policy Holder Name: (if other than self)**		**Policy Holder DOB:**	**Relationship to Patient:**	
Policy Number:	**Group Number:**	**Copayment Amount:**	**Policy Holder Place of Employment:**		

PATIENT'S NAME (PRINT) _____

SIGNATURE OF PATIENT OR GUARDIAN: _____**Date:** _____/_____/_____

Medical Information

Date_____

Patient Name_____ DOB: _____ Age_____

Height _____ Weight _____ Pharmacy Name and # _____

Referring Provider _____ Podiatrist: _____

Primary care provider _____ Cardiologist: _____

Occupation: _____ Place of work _____

Reason for visit_____

Symptoms: _____Date of first symptoms: _____

Medications: Please list all medications and provide a complete list if available

Name of Medication	Dosage	Name of Medication	Dosage

Allergies- include reaction

Medication	Reaction		
		Latex	Yes / No
		Shellfish/Seafood	Yes / No
		Contrast/Dye	Yes / No

Do you currently smoke? Yes / No Packs per day_____Years_____
Have you ever smoked? Yes / No Packs per day_____Years_____
Alcohol use? Yes / No Occasionally Daily

Marital Status (please circle): Married / Single / Divorced / Widowed

Past Family History: Please indicate which family members have or had any of the following:

____High blood pressure
____Diabetes
____High cholesterol
____Heart Disease
____Stroke
____Cancer (please specify)
____Varicose veins
____Other (please specify)

Do you have any of the following?

Diabetes	Arthritis
High Blood Pressure	Asthma/COPD
High Cholesterol	Acid Reflux
Heart Disease	Cancer
Blood Clots (legs/lungs)	Depression/Anxiety
Bleeding/Clotting disorder	HIV/Hepatitis
Kidney Disease	Sleep Apnea
Stroke/Mini stroke	Other

Heart Disease: Atrial Fibrillation: _____ **CABG/Stents**_____
History of MI/Heart Attack _____ Date: _____
Pacemaker/Defibrillator? Yes No

Are you currently on dialysis? Yes / No
If yes, please provide name of dialysis center and physician: _____

Have you ever had blood clots in your legs? Yes / No
If yes, please specify number of times: _____

Previous Surgeries:

DATE:	**Type of Surgery**
_____	_____
_____	_____
_____	_____
_____	_____

Total Pregnancies (if applicable):_____Total Births (if applicable):_____

How did you hear about Center for Vascular Medicine? Please Circle
Physician Employee Self Other (Specify)_____

Person to contact in case of emergency:

Name: _____ Phone: _____

Patient Email Address (for Patient Portal) _____

Patient Signature_____ Date: _____

Name: _____ DOB _____

PLEASE PRINT

HIPAA Policies – List anyone you authorize to discuss your medical and payment information.

Your health providers are automatically included. If you would like a copy of our HIPAA form, please ask the front desk.

(1) _____ Relationship: _____
(2) _____ Relationship: _____
(3) _____ Relationship: _____

I give permission for messages to be left at the following contact methods:

HOME PHONE	YES	/	NO	PREFERRED METHOD OF CONTACT
CELL PHONE	YES	/	NO	PREFERRED METHOD OF CONTACT
WORK PHONE	YES	/	NO	PREFERRED METHOD OF CONTACT

RELEASE OF INFORMATION FOR PAYMENT OF SERVICES

I authorize this office to release all information necessary for payment of services rendered, including medical records. I authorize any payers to pay benefits directly to this office. Any insurance requirements such as referrals or prior authorization are strictly patient responsibility. I understand that I am financially responsible for all services regardless of insurance benefits and am required to update my demographics and insurance with this office as necessary. I agree to promptly pay for the services rendered for me, or the above-named patient. If I fail to meet my financial commitment to Center for Vascular Medicine and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account.

Initial: _____

NOTICE OF PRIVACY PRACTICES

We use information that you provide us, including health information, to carry out treatment, payment, and health care operations. Please refer to our "Notice of Privacy Practice" for a more complete description. You have the right to review the notice before signing the sent. The terms or our Notice of Privacy Policy may change. You may obtain a revised notice from our office by calling (301)486-4690. You have the right to restrict the use of your health information to carry out treatment, payment, or health care operations. We are no required to agree to the restriction. We do agree to any restrictions; the agreement is binding to us. You have the right to revoke this consent at any time by notifying us in writing. Our address is as follows:7300 Hanover Drive Ste. 104, Greenbelt, MD. 20770. I hereby consent to Center for Vascular Medicine contacting my physician's office to release pertinent information for future follow up care. I hereby consent to the use and disclosure of my individuality identifiable health information for treatment, payment, and health care operations. I have been provided with a copy of the Notice of Privacy Practice.

Initial: _____

CANCELLATION / NO SHOW POLICIES

In order to strive for perfection, we have implemented the following No Show/ Cancellation policy for our office.

The goals of this policy are as follows:

- To reduce the number of lost or broken appointments due to patients not coming in for their scheduled time and/or not calling in advance to cancel their appointments.
- To make sure that those patients who want or need an appointment don't have to be displaced due to the inconvenience of those patients who don't co-operate with the office policy.

Our policy states:

- Any Missed/No Show Appointments for surgery, studies to be done or consultations that are not canceled in 48 hours prior to their appointment time, will be charged a $35 holding fee.

Initial: _____

SIGNATURE: _____ Date: _____