New Patient Instructions- Center for Vascular Medicine (CVM)

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 our CVM office:_____

Have a good day and we look forward to serving you in the very near future.

Your CVM team

Sanjiv Lakhanpal MD
Vinay Satwah D.O
Gaurav Lakhanpal MD
Michael Malone MD
Jessica Zaret MD
Kruti Patel PA-C

Annapolis
108 Forbes Street, 2nd Floor
Annapolis, MD 21401

Fairfax
8316 Arlington Blvd, Suite 515
Fairfax, VA. 22031

Glen Burnie
1600 Crain Highway South, Suite 409
Glen Burnie, MD 21061

Greenbelt
7300 Hanover Drive, Suite 104
Greenbelt, MD 20770

Prince Frederick
205 Steeple Chase Drive, Suite 302
Prince Frederick, MD 20678

Silver Spring
831 University Boulevard East, Suite 34
Silver Spring, MD 20903

T- 301-486-4690
F-301-486-4692

CENTER FOR Vascular Medicine

Medical Information

Date_____

Patient Name_____ DOB:_____ Age_____

Referring Provider:_____Podiatrist:_____

Primary care provider _____ Cardiologist:_____

Chief Complaint/Reason for Visit_____

Occupation: _____

Symptoms_____Date of first symptoms_____

Medications **List ALL other medications**

Name of Medication Dosage	Name of Medication Dosage
Aspirin	
Plavix	
Coumadin	
Xarelto	
Eliquis	
Insulin	

Allergies- include reaction

Medications:	Latex	Yes	No
	Shellfish/Seafood	Yes	No
	Contrast/Dye	Yes	No

Do you smoke? Yes No Packs per day_____Years_____ Date quit_____

Alcohol use? Yes No Occasionally Daily

Previous Surgeries:

Date	**Type of Surgery**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

CENTER FOR Vascular Medicine

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

Do you have any of the following? Circle all that apply

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

Heart Disease: Atrial Fibrillation:_____ CABG/Stents_____

History of MI/Heart Attack _____ When_____

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: _____

How did you hear about Center for Vascular Medicine? Please Circle

Physician Employee Self Friend

Other (Please specify) _____

Email Address_____

Alternate contact person and phone number: _____

Patient Signature_____

Consent for Disclosure of Protected Health Information

Patient Name_____ DOB_____

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.

Signature_____ Date_____

No Show/ Cancellation Policy

Welcome to the Center for Vascular Medicine. We care about your time and strive to keep the flow in our office going in a timely manner. 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 appointments 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.

Our office scheduled your appointment and reserved a time slot for your good faith. Please help us to keep your goal in offering our patients appointments and keep the flow in our office going in a timely manner.

Signature_____ Date_____

Sanjiv Lakhanpal MD
Vinay Satwah D.O
Gaurav Lakhanpal MD
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Center For Vascular Medicine Inc
7300 Hanover Dr Suite 104
Greenbelt, MD 20770-2250
(877) 474-0077

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
	$	
CITY, STATE ZIP	DEDUCTIBLE	
	$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
	$	
CITY, STATE ZIP	DEDUCTIBLE	
	$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

I certify that the information above is correct. I agree that insurance benefits for The Medical Clinic provider charges payable to the insured are to be made payable to The Medical Clinic and that physician benefits otherwise payable to the insured are to be made payable to The Medical Clinic. Any payments received for services rendered to me by The Medical Clinic may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. I acknowledge that I am fully responsible for all non-covered services, deductibles and co-payments. I further agree, in the event of default due to non-payment, to be responsible for collection fees, court costs, and/or legal fees, and there will be a $35.00 fee for all returned checks.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____