The Cardiovascular Care Group

Experience, Integrity, Innovation - Since 1963

Proudly Featuring the Vein Institute of New Jersey

Before you arrive to your first appointment, please see and complete the documentation checklist below:

☐ Patient Information Form (Downloaded from our website)

☐ Patient Medical History Form (Downloaded from our website)

☐ List of Medications (Please "list" all medications on the forms downloaded from our website)

☐ Insurance Cards

☐ Films and or Reports (if necessary)

☐ Referral and or Prescription Request to see our specialists (if required)

☐ Co-payment/ Deductibles Due? (We accept, cash, check, Master Card, Visa, American Express)

We also ask that you contact your insurance carrier and verify with them, that the physician you are seeing in our office, participates in your insurance plan. If you have any questions, do not hesitate to contact us at 973-759-9000.

We look forward to seeing you.

www.tcvcg.com **973-759-9000**

After completing these forms, please email to: info@tcvcg.com

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Patient Information:

Last Name: _____ First Name: _____ MI: _____ Gender: M ☐ F ☐

Address: _____ APT#._____ City: _____ State: ____ Zip: _____

DOB: _____ Age: ____ Cell #: _____ Home #:_____ Work #: _____

Marital Status: _____ Race _____ Ethnicity_____ Language _____ Social Security #: _____

Email Address: _____ Preferred Method of Contact: Cell____ Home ___ Work____

How did you first hear about The Cardiovascular Care Group? _____

Insurance Information:

Primary Insurance Name: _____ Subscriber Name: _____ Date of Birth: _____
Relationship to Insured: ☐ Self ☐ Spouse ☐ Other

Secondary Insurance Name: _____ Subscriber Name: _____ Date of Birth: _____
Relationship to Insured: ☐ Self ☐ Spouse ☐ Other

Referring MD: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax:_____

Primary Care MD.:_____Address:_____

City:_____ State:_____ Zip:_____ Phone: _____ Fax: _____

Dialysis Center:_____ Address _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Pharmacy: _____Address:_____

May we contact your pharmacy? YES ☐ NO ☐

Emergency Contact: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Authorized to discuss Medical Information? YES ☐ NO ☐

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I authorize payment of medical benefits to The Cardiovascular Care Group. I authorize The Cardiovascular Care Group to use or disclose any information for treatment, payment, and healthcare operations. I authorize that the physicians and/or employees of The Cardiovascular Care Group can contact me via all necessary means or leave me a message if they are unable to contact me directly.

Patient Signature:_ _____ Date: _____

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NAME: _____ DATE OF BIRTH: _____ DATE: _____

1. REGARDING YOUR PAST MEDICAL HISTORY:

	YES	NO
1. Do you have HIGH BLOOD PRESSURE?		
2. Do you have DIABETES?		
3. If so, do you take INSULIN?		
4. Do you have HEART PROBLEMS? If so, what condition? _____		
5. Do you have a PACEMAKER, DEFRIBILLATOR, or LOOP MONITOR?Which one?_____		
6. Have you had a prior HEART ATTACK? If so, what year? _____		
7. Do you have ANGINA?		
8. Do you have HIGH CHOLESTEROL?		
9. Do you have LUNG DISEASE? If so, please list _____		
10. Do you have KIDNEY DISEASE?		
11. If so, are you on DIALYSIS? When did you begin? _____		
12. Do you have problems with your LIVER?		
13. Have you ever had a STROKE OR TIA?		
14. Do you have RHEUMATOID ARTHRITIS?		
15. Have you ever had CANCER?		
16. Have you received the Pneumonia vaccine? If so, when? _____		
17. Have you received the Flu vaccine? If so, when? _____		

2. PLEASE LIST ALL OF YOUR MEDICATIONS – include supplements and herbals:

MEDICATION NAME	DOSAGE	FREQUENCY

3. PLEASE LIST ANY ALLERGIES YOU HAVE:

4. HAVE YOU HAD ANY PRIOR SURGERIES? If so, please list:

OPERATION PERFORMED	YEAR

NAME: _____

5. REGARDING YOUR SOCIAL HISTORY:

	YES	NO
1. Are you currently employed? If so, type of job? _____		
2. If not, are you retired? If so, from what? _____		
3. Have you been exposed to any known toxins? If so, list _____		
4. Do you presently smoke? If so, how much? _____		
5. If not, have you ever smoked regularly? If so, when? _____		
6. Do you drink alcohol? If so, how much? _____		
7. Do you live alone? If not, with whom do you live? _____		

6. REGARDING YOUR FAMILY HISTORY:

	MOTHER	FATHER	SIBLINGS
Alive?	*YES* ☐ *NO* ☐	*YES* ☐ *NO* ☐	*YES* ☐ *NO* ☐
Age at Passing or Present			
Cause of Death			
Diabetes?	*YES* ☐ *NO* ☐	*YES* ☐ *NO* ☐	*YES* ☐ *NO* ☐
Heart Disease?	*YES* ☐ *NO* ☐	*YES* ☐ *NO* ☐	*YES* ☐ *NO* ☐
High Blood Pressure?	*YES* ☐ *NO* ☐	*YES* ☐ *NO* ☐	*YES* ☐ *NO* ☐
Cancer? If so, specify:	*YES* ☐ *NO* ☐	*YES* ☐ *NO* ☐	*YES* ☐ *NO* ☐

7. GENERAL OVERALL CONDITION (PLEASE EXPLAIN ALL "YES" RESPONSES):

	YES	NO	EXPLANATION, IF NECESSARY
1. Have you have a persistent FEVER?			
2. Have YOU LOST/GAINED WEIGHT in the last 6 months?			
3. Have you been excessively FATIGUED OR IRRITABLE?			
4. Have you had problems with your EYES?			
5. Have you had partial LOSS OF VISION in either eye?			
6. Have you had problems with your EARS?			
7. Have you had SWALLOWING PROBLEMS?			
8. Have you had DENTAL PROBLEMS?			
9. Have you had CHEST PAINS OR PALPITATIONS?			
10. Have you had SHOULDER OR NECK PAIN?			
11. Do you have PAIN IN YOUR LEG(S) when you walk?			*Which leg? RIGHT* ☐ *LEFT* ☐
12. How far can you walk (in blocks)?			
13. Do your ANKLES swell?			
14. Have you ever had PHLEBITIS OR DVT?			
15. Do you get SHORT OF BREATH?			
16. Do you have a COUGH and/or produce SPUTUM?			
17. Do you have NAUSEA, VOMITING OR DIARRHEA?			
18. Have you had BLOOD in your URINE OR STOOLS?			
19. Do you have problems URINATING?			
20. Do you have JOINT PAINS (knee, elbow, shoulders)?			
21. Do you BRUISE EASILY?			
22. Do you have DISCOLORATION or your skin?			
23. Do you have DIZZINESS OR NUMBNESS?			
24. Do you have difficulty SPEAKING?			
25. ***Any ADDITIONAL medical conditions not listed above? Please list!			

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ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES/ CONSENTS

I hearby acknowledge that I have received or have been given the opportunity to receive a copy of The Cardiovascular Care Group's Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have had the opportunity to receive/read the Notice of Privacy Practices.

_____	_____	_____
Patient Name (PRINT)	Signature	Date

PATIENT CONSENT FOR ELECTRONIC MAIL

I understand the risks associated with the communication of e-mail between my provider and me, and I consent to the use of electronic mail. While The Cardiovascular Care Group will use reasonable means to protect the security and confidentiality of e-mail information, I understand that they cannot guarantee the security and confidentiality of the e-mail communication. The Cardiovascular Care Group will not forward e-mails to independent 3rd parties, except as authorized or required by law. I also agree that The Cardiovascular Care Group will not be liable for improper disclosure of confidential information that is not caused by intentional misconduct.

_____	_____	_____
Patient Name (PRINT)	Signature	Date

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THE CARDIOVASCULAR CARE GROUP FINANCIAL POLICY

Because healthcare benefits and coverage have become increasingly complex, we have developed this policy to detail our financial requirements to help you better understand your responsibilities. Upon check in for your appointment, we will ask you for your signature requesting that you have read, understand and accept our financial policy.

It is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from a primary care physician, pre-certification, limits on outpatient charges, non-covered cosmetic services, specific physicians and/ or hospitals to use. You should be knowledgeable of any deductibles, co-payments, and coinsurance. This applies to all payers regardless of whether or not our physicians participate.

If you are having a cosmetic procedure (injection sclerotherapy, surface laser treatment, Botox or Juvéderm), payment is required at the time services are rendered. We do not submit claims for these procedures to third party payers.

The payment of fees for services is the direct responsibility of the patient. Your health benefit plan involves an arrangement between you, the enrollee, and the insurance company, HMO or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what the insurance company determines is medically necessary. We will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance.

Payment Policy Schedule*:

Co-payments	Full payment is due at time of service.
Deductible and coinsurance	Full payment is due at time of service.
Non-covered service	Full payment is due at time of service.
Non-participating insurance plan	Full payment is due at time of service.

Other charges/ fees*:

Missed Appointment Fee	The office requires at least 24 hours' notice when canceling an appointment. Failure to provide this notice will result in a $25.00 charge to your account.
Rebillable Fee	$10.00
Return Check Fee	$25.00

* Subject to change at any time

We realize that medical care can become very expensive. If you have concerns about your ability to pay for services, we ask that you contact us for assistance in the management of your account.

Should you have any questions with regard to our financial policies we encourage you to ask. It is our goal, not only to provide the best quality of medical care, but to help you by answering any questions you might have.

I have read the office financial policy and agree to all terms and conditions.

Signature: _____ Date: _____