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**

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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: _____

Other Specialists:

Name:_____ Phone:_____ Name:_____ Phone: _____

Dialysis Center:_____ Address:_____

City: _____ Phone: _____ Which days do you receive dialysis? _____

Pharmacy: _____ Address: _____

City**:** _____ May we contact your pharmacy? YES NO

Emergency Contact: _____ Address: _____

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

Authorized to discuss Medical Information? YES NO

If no, who can we speak to regarding your medical information: Name:_____ Phone: _____

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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, DEFIBRILLATOR or LOOP MONITOR? Which one? _____		
5. Have you had a prior HEART ATTACK? If so, what year? _____		
6. Do you have ANGINA?		
7. Do you have HIGH CHOLESTEROL?		
8. Do you have LUNG DISEASE? If so, please list _____		
9. Do you have KIDNEY DISEASE?		
10. If so, are you on DIALYSIS? When did you begin? _____		
11. Do you have problems with your LIVER?		
12. Have you ever had a STROKE OR TIA?		
13. Do you have RHEUMATOID ARTHRITIS?		
14. Have you ever had CANCER?		
15. Have you received the Pneumonia vaccine? If so, when? _____		
16. Have you received the Flu vaccine? If so, when? _____		
17. Have you received the COVID vaccine? Which one?_____Date1?_____ Date 2?_____		
18. Have you received the COVID booster? If so, which one? Date?		
19. Have you had a mammography? If so, when? _____		
20. Have you had a colonoscopy? 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*	Unsure	*YES*	*NO*	Unsure	*YES*	*NO*	Unsure
Age at Passing or Present									
Cause of Death									
Diabetes?	*YES*	*NO*	Unsure	*YES*	*NO*	Unsure	*YES*	*NO*	Unsure
Heart Disease?	*YES*	*NO*	Unsure	*YES*	*NO*	Unsure	*YES*	*NO*	Unsure
High Blood Pressure?	*YES*	*NO*	Unsure	*YES*	*NO*	Unsure	*YES*	*NO*	Unsure
Cancer? If so, specify:	*YES*	*NO*	Unsure	*YES*	*NO*	Unsure	*YES*	*NO*	Unsure

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's Initials_____

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's Initials_____

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, applicable 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 Juvederm), payment is required at the time services are rendered. We do not submit claims for these procedures to third party payers.

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*:

Rebillable Fee:	$10.00
Return Check Fee:	$25.00

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's Initials _____

I have read and agree to all of the policies above:

_____ _____ _____

Patient Name (PRINT) Signature Date