Daniels Vein & Cosmetic Center
Richard J. Daniels, M.D. PA
9500 K. Johnson Blvd, Suite 3, Bordentown, NJ 08505
Tele: 609-298-0033 Fax: 609-298-0043
Website: *www.danielsveincenter.com*

PATIENT REGISTRATION FORM

Accurate patient information is an important part of quality medical care. We ask that you take a few minutes and complete the following information to update your medical records.

How did you hear about our practice? ____________________

Patient Name: ____________________ DOB: ____________________

Address: ____________________

____

Home Phone: ____________________ Cell Phone: ____________________

Email Address: ____________________ Age: ____________________

□ Female □ Male Marital Status S / M / W / D Social Security #: ________-_______-________

Primary Physician: ____________________ Phone: ____________________

Address: ____________________

Referring Physician: ____________________ Phone: ____________________

Address: ____________________

Employment:

Occupation: ____________________

Employer Name: ____________________ Phone: ____________________

Address: ____________________

Primary Insurance Information: *If you are Primary Cardholder, write SAME*

Insurance Co Name: ____________________ Effective Date: ____________________

Policy ID #: ____________________ Group # ____________________

Cardholder's Name: ____________________

Cardholder's Address: ____________________

Cardholder's DOB: ____________________ Relationship to Patient: ____________________

Secondary Insurance Information: *If you are Primary Cardholder, write SAME*

Insurance Co Name: ____________________ Effective Date: ____________________

Policy ID #: ____________________ Group # ____________________

Cardholder's Name: ____________________

Cardholder's Address: ____________________

Cardholder's DOB: ____________________ Relationship to Patient: ____________________

Emergency Contact:

Name: ____________________ Phone: ____________________

Relationship to Patient: ____________________

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Patient Last Name: ______________________________ First Name: ____________________ DOB:_________

Tobacco Use: Yes No How much? _____________ Alcohol Use: Yes No How Much? __________________

Have you ever been hospitalized before? Yes No

If yes, please specify for what reason and when? ____

____

Have you ever had any significant **Surgery**? Yes No

If yes, please explain along with dates? ____

____

Please list any **Allergies**: ____

____

Please list any **medications** you are currently taking (please include dose and how often): _____________________

____

<u>Vein History</u> ** ***This information in important for insurance approval, please complete accurately.***

Reason For Visit: ____

What is the reason why you are seeking treatment? Cosmetic Medical

Have you seen any other doctors for treatment of your veins? Yes No

If so, please explain: ____

Do you or have you ever worn compression stockings? Yes No How Long: _________________________

If yes, please list what type you use(d): _____________________________________ Did they Help? Yes No

Have you ever had a blood clot in your legs? Yes No

If so, please detail which leg and when: ____

Do you experience any of the following symptoms in your legs (please circle all that apply)?

Pain/Aching	Heaviness	Tiredness/Fatigue	Itching/Burning
Swollen Ankles	Leg Cramps	Throbbing	Restless Legs

Any other leg symptoms? ____

Have you taken any OTC medications for your leg symptoms? Yes No If so, how long? __________________

If so, what do you take and how much? ____

Do you have any problems walking? Yes No

If so, please explain: ____

Are your symptoms worse at the end of the day? Yes No

Are the problems you are having interfering with your lifestyle? Yes No

Do you stand for long periods of time? Yes No

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PHOTOGRAPH CONSENT

Photographic documentation will be taken. I hereby **DO __ DO NOT __ authorize the use of my photographs for teaching and/or website purposes.

PATIENT DEMOGRAPHIC INFORMATION AUTHORIZATION

Daniels Vein & Cosmetic Center is participating in the U.S. Department of Health and Human Services' "Meaningful Use" program in order to provide better patient care. This program will lead to improved electronic communications and a more complete medial record for our patients.

Please choose one from each section:

Race:

□ American Indian or Alaskan Native
□ Asian
□ Black or African American
□ Native Hawaiian or Other Pacific Islander
□ White
□ Unknown/Other ______________________________
□ I prefer not to report

Ethnicity:

□ Hispanic or Latino
□ Not Hispanic or Latino
□ I prefer not to report

Primary Language:

□ English
□ Spanish
□ Portuguese
□ Polish
□ French
□ German
□ Italian
□ Other Language _________________________
□ I prefer not to report

I, ____(Print Name), hereby authorize Daniels Vein & Cosmetic Center to: (1) use the demographic information listed above for purposes of completing my electronic health record; (2) disclose such information to government officials and third parties as necessary to comply with state and federal laws and regulations; (3) use and/or disclose such information in connection with demonstrating the Practice's meaningful use of EMR technology; and (4) use and/or disclose such information as described in the Practice's HIPPA policies and procedures, and as otherwise permitted by HIPPA laws and regulations.

____ Patient Signature

__________________________ Date