SKYLANDS VASCULAR SPECIALISTS
BOBBY RUPANI, M.D., RVT

PATIENT REGISTRATION FORM

(All information is strictly confidential)

Today's Date _____

☐ New Patient ☐ Change of Address ☐ Change of Insurance

REFERRED BY: _____

PATIENT INFORMATION

Last Name_____ First Name _____ M.I. ___

Address _____ Apt/Unit _____ AGE _____

City_____ State_____ Zip _____

Home Phone_____Office phone_____cell_____

Date of Birth_____ Social Security Number_____

Best method to reach you? phone_____mail_____ email_____
If by phone do you want us to leave a message?_____

Email address _____
You are: Male_____ Female_____

Marital Status: Single☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Preferred Language_____ Race_____ Ethnicity_____

Primary Care Physician _____PHONE_____
Address_____

Emergency Contact: Name _____ Phone _____

PHI DISCLOSURE- Whom may we speak to on your behalf regarding your personal health information?_____

This will be in effect until you notify us to revoke this. Authorization may can be revoked at any time.

Patient Employer_____ Phone Number_____
Address_____
City, State, Zip_____
Benefits Contact _____Phone_____

Please sign:
I understand this office uses commercial Email and texting _____
I have been given a copy of this office's Privacy Policy _____

REASON FOR VISIST

_____

PRIMARY INSURANCE COMPANY

Effective Start Date _____ Carrier Name _____
Plan _____ Contract Number _____Co-Pay Amount_____

Subscriber Information:

Subscriber Last Name_____First Name_____ M.I._____

Relationship to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐
Student ☐ Ret Sub ☐ Hand Child ☐ Surv Spouse ☐ Spon. Dep. ☐

Coverage Name _____ Coverage Code _____

Group Name _____Group Number_____

If Subscriber Address is Different from Patient Address, fill in below:

Address_____Apt/Unit_____
City_____ State_____ Zip_____
Social security_____ **Date of Birth**_____
Relationship to Responsible-Party: Self ☐ Spouse ☐ Child ☐ Other ☐
Sex: Male ☐ Female ☐

SECONDARY INSURANCE COMPANY

Effective Start Date _____ Carrier Name _____
Plan _____ Contract Number _____Co-Pay Amount_____

Subscriber Information:

Subscriber Last Name_____ First Name_____ M.I._____

Relationship to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐
Student ☐ Ret Sub ☐ Hand Child ☐ Surv Spouse ☐ Spon. Dep. ☐

Coverage Name _____ Coverage Code _____COPAY_____

Group Name _____Group Number_____

If Subscriber Address is Different from Patient Address, fill in below:

Address_____Apt/Unit_____
City_____ State_____ Zip_____
Social security number _____**Date of Birth**_____

ASSIGNMENT OF BENEFITS /AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize payment directly to physicians providing services for which benefits are payable. I hereby authorize the release of pertinent medical information to insurance carriers.

Signature_____ Date _____

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges for services to me, including the remaining balance of possible insurance benefits payments. I will also pay all recovery costs if my account is referred to collection.

Signature_____ Date _____

BOBBY RUPANI , M.D. RVT

PERSONAL MEDICAL DATA SHEET

DO YOU HAVE ANY ALLERGIES? If so, please list them

ARE YOU TAKING ANY MEDICATIONS? If so, please list names and dosage

PHARMACY **PHONE NUMBER**
ADDRESS **FAX NUMBER**
?

FAMILY HISTORY- **MOM , DAD , SIBLINGS , SELF pls ck off**

HEART DISEASE

HIGH BLOOD PRESSURE(HTN)

DIABETES(DM)

STROKE (CVA)

HIGH CHOLESTEROL

ASTHMA

KIDNEY PROBLEMS/RENAL FAILURE

ANY OTHER MEDICAL ISSUES HEIGHT _____ WEIGHT_____

PATIENT PREVIOUS SURGERY (If any)
Year

Year

Year

DO YOU DRINK ALCOHOL? __YES __NO
If yes how much?

DO YOU SMOKE? __YES __NO
If yes how much? Every day? ___ Some days?__ Never? __ Former?___

WHAT IS YOUR PRESENT COMPLAINT?

PATIENT NAME:

REVIEW OF SYSTEMS-
PLEASE CHECK OFF ALL THAT APPLY TO YOU.

GENERAL: _Significant Change In weight _Unusual Fatigue _Fever, Night Sweats, chills _Excessive Thirst _Tumor _Sleeping _Change in Mental Status _DIABETES _HYPERTENSION **NORMAL**	**EYES:** _Swelling, Redness, Pain _Vision Loss _Blurry/Double Vision _Glucoma **NORMAL.....** **PSYCHIATRY** _Anxiety _Depression _Suicidal thoughts **NORMAL**	**ENDOCRINE:** _Goiter _Changes Hat, Ring, Shoe Size _Testicle Lump/Pain _Thirst/Urination _Heat/Cold Intolerance _Hyperthyroidism _Hypothyroidism **NORMAL**
HEAD AND NECK _Hearing Trouble _Vertigo or Faintness _Dental Problems _Pain in throat or trouble swallowing _Sinusitis/Hayfever _Ringing _Voice Change **NORMAL**	**GASTROINTESSTINAL** _Appetite _Difficulty Swallowing _Abdominal pain _Abdominal dissention _Nausea, Vomiting _Indigestion _Signs of Blood _Diarrhea/frequent BM _Black or Bloody stool **NORMAL**	**NEUROLOGIC** _Loss of Memory _Change in Personality _Change in Gait _Unusual Muscle Weakness _Numbness or Tingling _Seizures _Headache _Stroke _Head injury _Forgetfulness _Focal weakness **NORMAL**
SKIN _Rashes _Erythema _Dermatitis _Nipple Discharge _Breast Masses **NORMAL**	**URO GENITAL** _Genital infection, pain, sores _Frequency _Dysuria _Anemia _Loss of control _Nocturia _Difficulty starting _Stones/blood _Sexual dysfunction **NORMAL**	**BACK SPINE** _Herniated disc _Back pain NORMAL **HEMATOLOGIC** _Bleeding _Anemia _Lymph nodes NORMAL
Other medical issues? Pls list	**CARDIO-VASCULAR-RESPIRATORY** _Chest pain _Cough (sputum) productive? Or not? _Shortness of breath _Wheezing _Hemoptysis _Irregular Heart Beat _Orthopnea or PND _Edema _Claudication **NORMAL**	**MUSCULOSKELATAL** _Bones/Joints _Lymph nodes _Pulses _Edema _Calf Tenderness _Extremities **NORMAL**

PATIENT NAME:

SIGNATURE:

DR RUPANI SIGNATURE **DATE**