ISLAND SURGICAL AND VASCULAR GROUP, P.C.
15 PARK AVENUE
BAY SHORE, L.I., N.Y. 11706
TELEPHONE: (631) 581-4400
FAX: (631) 277-3750

CONFIDENTIAL PATIENT INFORMATION

Last Name:_____**First Name**_____
Birth date:_____**Soc Sec #:** _____ - _____- _____ **[ ] MALE [ ] FEMALE**
Address:_____
City:_____**State**:_____**Zip**:_____ - _____
Home Phone:_____**Cell #:**_____**Work #**_____
Email: _____
Check One: [ ] Non- Hispanic [ ] Hispanic [ ] Other [ ] Decline
Check One : Primary Language [ ] English [ ] Spanish
Check One [ ] Caucasian [ ] Black [ ] Asian [ ] Other [ ] Decline [ ] Other [ ] Decline
Employer:_____**Phone:**_____**Ext:**_____
Employer Address:_____**City**:_____ **State:**_____**Zip**:_____
Check one: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated
Emergency Contact:_____**Relationship**:_____
Home Phone:_____ **Cell #:**_____

HIPAA ACKNOWLEDGEMENT

The HIPPA policy provides national standards to protect the privacy of personal health information. A copy is posted in the waiting room. I understand the Privacy Practices for Island Surgical & Vascular Group and acknowledge a copy is available upon request.

Signature_____.
Please list names of anyone that you authorize to have access to your healthcare and account information at Island Surgical and Vascular Group. (If no names are listed you will be the only person we will discuss your healthcare and account information with)

_____ _____

_____ _____

Please indicate which telephone # you would prefer to receive calls regarding healthcare information;
Hm#_____Cell#_____Work#_____
Please indicate which telephone # we can leave a message regarding your healthcare
[ ] Home answering machine [ ] Cell voice mail [ ] Work voice mail

MEDICAL INFORMATION

Family/Medical Doctor:_____ Phone:_____

Referring Doctor:_____ Phone:_____

PHARMACY _____PHONE_____

PHARMACY ADDRESS -_____

Signature of patient/guardian: _____ Date _____

****IF TODAY'S TREATMENT IS A JOB RELATED INJURY OR MOTR VEHIICLE ACCIDENT, SEE RECEPTIONIST FOR ADDITIONAL FORM*****

INSURANCE INFORMATION

ALL REFERRALS AND COPAYMENTS ARE DUE BEFORE EXAMINATION. PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST UPON COMPLETION OF THIS FORM.

Insurance Co:_____ Policy #:_____ Group #:_____

Insurance Co. Address:_____ City:_____ State:_____ Zip:_____

Insurance Phone #:_____Name of Insured:_____Relation:_____

Birthdate:_____Soc Sec#:_____

INSURANCE AUTHORIZATION

I hereby authorize Island Surgical & Vascular Group, P.C as my designated representative.
I authorize Island Surgical & Vascular Group, P.C. to appeal any and all claim determinations at the above named insurance carrier.
I hereby authorize the above named insurance carrier in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative concerning the following all medical and financial information contained in my insurance files.

_____ _____
Signature of patient Date

SECONDARY INSURANCE INFORMATION

Insurance Co:_____ Policy #:_____ Phone #:_____

Insurance Co. Address:_____ City:_____ State:_____ Zip:_____

Name of Insured:_____ Relation:_____

Birthdate:_____Soc Sec#:_____

INSURANCE AUTHORIZATION

I hereby authorize Island Surgical & Vascular Group, P.C as my designated representative.
I authorize Island Surgical & Vascular Group, P.C. to appeal any and all claim determinations at the above named insurance carrier.
I hereby authorize the above named insurance carrier in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative concerning the following all medical and financial information contained in my insurance files.

_____ _____
Signature of patient Date

PLEASE COMPLETE ALL AREAS OF FORM; YOUR CHART CANNOT BE PROCESSED WITHOUT THIS FORM BEING COMPLETED. IF YOU NEED ASSISTANCE, PLEASE ASK.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to ISLAND SURGICAL & VASCULAR GROUP for any services furnished me by the physicians of ISLAND SURGICAL & VASCULAR GROUP. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of patient _____ Date _____

MEDICAL RECORDS CONSENT

I hereby authorize ISLAND SURGICAL & VASCULAR GROUP to access my medical records at Long Island community Hospital in Patchogue, NY, Good Samaritan Hospital in West Islip, NY and St. Catherine of Siena in Smithtown, N.Y. **This authorization is only valid for medical records related to my medical treatment or necessary for insurance purposes.**

Signature of patient _____ Date _____