Elite Veins NY

Bradley A. Radwaner, M.D., FACC
136 East 57th. St. Suite 1001
New York NY 10021

Patient Registration Form

Today's date:	Primary Care Physician (PCP):	Pharmacy name:	Pharmacy address:	Pharmacy phone no.:
/ /				( )

PATIENT INFORMATION

Patient's last name:	First name:	Middle:	□ Mr. □ Miss □ Mrs. □ Ms.	Marital status (circle one):
				Single / Mar / Div / Sep / Wid

Birth date:	Age:	Sex:
/ /		□ M □ F

Is the above your legal name?
□ Yes □ No

If not, what is your legal name? (Former/legal name):

Street address:	Social Security no.:	Home phone no.:	Email Address:
		( )	@

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

How were you referred to us? (please check one box):
□ Dr. □ Insurance Plan □ Hospital □ Family or Friend □ Google Search □ Google Ad □ Facebook Ad. □ Yelp □ Other

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (If different):	Home phone no.:
	/ /		( )

Is this person a patient here?
□ Yes □ No

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?
□ Yes □ No

Please Indicate primary insurance:
□ Medicare □ [Insurance]

Insurance company name:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Policy no.:	Group no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:
□ Self □ Spouse □ Child □ Other

Name of secondary Insurance (If applicable):	Subscriber's name:	Policy no.:	Group no.:

Patient's relationship to subscriber:
□ Self □ Spouse □ Child □ Other

IN CASE OF EMERGENCY

Name of emergency contact (not living at the same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize this practice or Insurance company to release any information required to process my claims.

Patient/Guardian signature:	***Date:***

PERSONAL HEALTH HISTORY

Name _____ Date _____
Address _____
Home phone _____ Work phone _____
Emergency contact _____ E-mail address _____

Gender male _____ female _____

Age _____ Birthdate _____ Weight _____ Height _____

Physician's name _____ Physician's phone _____
Does your physician know that you are participating in an exercise/fitness program? yes ____ no
Date of last physical examination _____

Are you taking any medications?
no ____ yes ____ (Please list medications and reasons for usage below)

Medication	Reason for usage
_____	_____
_____	_____
_____	_____
_____	_____

Are you taking any vitamins or dietary supplements?
no ____ yes ____ (Please list supplements and reasons for usage below)

Supplement	Reason for usage
_____	_____
_____	_____
_____	_____
_____	_____

Do you now, or have you had in the past:	yes	no
1. History of heart problems, chest pain or stroke?	☐	☐
2. Increased blood pressure?	☐	☐
3. Any chronic illness or condition?	☐	☐
4. Do you ever get dizzy, lose your balance or lose consciousness?	☐	☐
5. Difficulty with physical exercise?	☐	☐
6. Advice from physician not to exercise?	☐	☐
7. Recent surgery (last 12 months)?	☐	☐
8. Pregnancy (now or within last 3 months)?	☐	☐
9. History of breathing or lung problems?	☐	☐
10. Swollen, stiff, or painful joints?	☐	☐
11. Foot problems?	☐	☐
12. Back problems?	☐	☐
13. Any significant vision or hearing problems?	☐	☐
14. Diabetes or thyroid condition?	☐	☐
15. Cigarette smoking habit?	☐	☐
16. Do you ever drink alcoholic beverages?	☐	☐

17. Increased blood cholesterol? ☐
18. History of heart problems in immediate family? ☐
19. Hernia, or a condition that may be aggravated by lifting weights? ☐
20. Do you have asthma? ☐

Please explain any yes answers below. (If necessary use the back of this page)

Do you have any other medical conditions or problems not previously mentioned? If so, please explain.

FAMILY HISTORY

Father
Current age _____
Father's general health is: excellent ___ good ___ fair ___ poor
Reason for fair/poor health is? _____

Mother
Current age _____
Mother's general health is: excellent ___ good ___ fair ___ poor ___
Reason for fair/poor health is? _____

Siblings
Number of brothers _____ Number of sisters _____ Age range _____
Any health problems? Please explain. _____

Have any of your BLOOD relatives had:	yes	no
1. Heart attack under age 50?	☐	☐
2. Stroke under age 50?	☐	☐
3. High blood pressure?	☐	☐
4. Elevated cholesterol?	☐	☐
5. Diabetes?	☐	☐
6. Asthma or hay fever?	☐	☐
7. Heart operations?	☐	☐
8. Obesity?	☐	☐
9. Leukemia or cancer under age 60?	☐	☐

EXERCISE AND PHYSICAL ACTIVITY

For the following questions, please mark which best applies to you.

Are you currently involved in a regular fitness program? yes ___ no

Are you involved in physical activities of daily living? yes ___ no ___
(walking, gardening, etc.)
If yes, what type and how often? _____

Are you involved in cardiovascular exercise or a group fitness program? yes no
If yes, what type and how often? _____

Are you involved in a strength training/weight lifting program? yes ___ no ___
If yes, what type and how often? 2 _____

Are you involved in any sports? yes no
If so, what sports and how often? _____

For the following questions, mark which best applies to you.

Do you consider yourself:

- ☐ sedentary
- ☐ lightly active (sporadic workouts, lawn work, little aerobic work)
- ☐ moderately active (work out 1-2 days/week for at least 15-30 minutes)
- ☐ highly active (work out three or more days/week at least 30-45 minutes)

Do you believe that you are physically fit?

- ☐ no
- ☐ less than average
- ☐ average
- ☐ above average
- ☐ outstanding
- ☐ don't know

Indicate the main reason you exercise or why you want to begin an exercise program.

- ☐ it is good for my health
- ☐ my doctor told me to
- ☐ it makes me feel good
- ☐ helps to relieve stress
- ☐ I am trying to lose weight
- ☐ other _____

What activities would/do you prefer in a regular exercise program?

- ☐ walking and/or running
- ☐ swimming
- ☐ stationary cycling
- ☐ stretching
- ☐ strength/resistance training
- ☐ not sure
- ☐ racquetball or squash
- ☐ tennis
- ☐ basketball
- ☐ rowing
- ☐ group fitness classes
- ☐ other _____

GOAL ASSESSMENT FORM

Name _____ Date _____

Goals should be: **SMART** (example goal: I want to lose 2 percent body fat within 6 months.)

S ~ Specific: *What will you do?* (i.e. lose weight)
M ~ Measurable: *How will you measure it?* (i.e. percent body fat, BMI)
A ~ Attainable: *Is this something you can attain?*
R ~ Realistic: *Can you realistically reach this goal?*
T ~ Set on a time line: *When do you want to reach this goal?*

Please fill out the goals and objectives below. You may want to wait and set these goals with the guidance of your personal trainer.

Long term goals (Where do you want to be in 6 months to a year?)
1._____
2._____
3._____

Short term objectives (What small things will you do to accomplish your long term goals?)
1._____
2._____
3._____
4._____

Fitness goals (may be similar to goals and objectives above)

1. Cardiorespiratory endurance

_____
_____

2. Muscular strength and endurance

_____
_____

3. Flexibility

_____
_____

4. Body composition/nutrition

_____
_____

For use of NU Fitness Staff

Notes: _____
_____
_____
_____
_____

Elite Veins NY

Bradley A. Radwaner, M.D., FACC

MEDICAL DIRECTOR

136 East 57th St. Suite 1001
New York NY 10022
Telephone (212) 717-0666
Facsimile (212) 717-2399

Dear Patient,

Our practice was one of the first in Manhattan to have full electronic medical records, web-based and security protected. This provided 24/7 availability of your medical records along with unsurpassed organization of your chart. We provided an internet-based patient portal which allows you to view lab results, schedule appointment, review statement and ask non-urgent medical question on line.

Now we have the capability of directly E-prescribing prescriptions to your pharmacy, whether it is the local New York neighborhood or a mail order pharmacy, hundreds of miles away. In order to do this we need you to provide us with your pharmacy's most current information.

Please complete the form below

Patient's Name: _____

Pharmacy's Name: _____

Address: _____

Telephone: _____

Fax: _____

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Please be advised that patients who do not call the office 24 hours prior to canceling their appointment or do not show up, will be charged $50.00 for the time set aside for the appointment. These charges will not be covered by insurance.

_____

Patient's Name

_____

Patients Signature

_____

Date

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CREDIT CARD ON FILE

The increasing number of delays and denials by insurance companies in paying your medical claims requires our office to maintain a credit card on file for each patient. If an outstanding balance remains unpaid 90 days after your claim has been filed by our office the credit card on file will be charged. Subsequent insurance company payments will be routed to patients directly.

New York State Law requires all insurance companies to process medical claims within 45 days. The insurance industry's failure to follow this law requires us to make these administrative changes. Statement are sent monthly to keep you informed of any outstanding insurance claims.

Our office will charge your credit card for any unpaid balances due to us 90 days after the professional services were provided.

I,_____ authorize the use of my credit card described below For the charges related to professional service provided by Dr. Bradley Radwaner.

Credit Card Type: _____

Credit Card Number: _____

Expiration Date: _____ Security Code:_____

Name of Card Holder: _____

Signature: _____

Date: _____

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LAB REPORTS ARE AVAILABLE TO YOU ON THE PATIENT PORTAL

The Patient Portal allows you through the internet to:

- Review your laboratory results
- Request appointments
- Request prescription refills
- Review your statement
- Review the accuracy of your personal information
- Ask non-urgent questions

Please log into our website at **www.eliteveinsny.com**
Click on the patient log-in icon

User name: Use your first and last name [NO SPACE or COMMA]
Password: First 2 letters of your first name, first 2 letters for your last name and your year of birth.
Example: John Smith
Date of Birth: 01/01/1900
User Name: johnsmith
Password: josm1900

Once you have logged in you may reset your password.

-Welcome to the Patient Portal. We hope you find it helpful and informative.

Bradley A. Radwaner, M.D., FACC