Vascular Institute of Southern Nevada, Kenneth J. Shah MD *(v.April 2020.001)*

Providing complete information below allows us to communicate with you and submit your claims.

We are using a new electronic medical record system that will allow improved healthcare quality and delivery to our patients.

To allow better communication to our patients on tests, diagnosis and prescription medications we are setting up a patient portal to allow you to have access to your health record. We will be using text messaging, email and/or voice messaging,

Future appointment reminders will be done electronically by use of Text Messaging or automated calls.

To allow full use of future technology; please visit our PATIENT PORTAL; we will give you a username and temporary password to your email. Please write down below your EMAIL and CELL PHONE number.

Patient's Full Name:_____Date: _____

Do you have another name you use or have had previously?: _____

Sex: __Male __Female ___Other _____

Race __American Indian/Alaskan __Asian__Hawaiian/Pacific Islander__Black/African American __White __Hispanic _Other

Ethnicity: __Hispanic/Latin __NOT Hispanic/Latin __Refused to Report

Language: __English__Spanish __Refuse to Report __Native Language: _____

"Y" - I give permission to release of Medical Data to other organizations in order to adjudicate the claim.

"Y" - I give permission to review my prescription history from external sources.

Pharmacy Info (1st Choice): _____ (name/address/phone #)

Pharmacy Info (2nd choice): _____ (name/address/phone #)

Mail Order ID: _____ PLAN TYPE: _____

Marital Status: __Divorced __Married __Partner __Single __Unknown __Widowed __Legally Separated

DATE OF BIRTH: _____/_____/_____Age:_____ Social Security No: _____

Referring Doctor: _____ Primary Care Doctor (SPECIAL): _____

MAILING ADDRESS: _____ _____

Street City

State Zip

REMINDERS via Email via the Patient Portal automatic; additionally we need the following info:

PREFERRED COMMUNICATION with VOICE and/or SMS Text Messaging (*please check all of them ideally*):

__Enabled VOICE Message to my HOME phone #: _____

__Enabled VOICE Message to my WORK phone #: _____

__Enabled SMS Message to my *CELL phone #:* _____

Preferred time to call is in the morning as default; or you may request either time: _afternoon _evening

Reminders for now include Appointments; future reminders include Lab Results, Health Maintenance, Rx Confirmation & Other.

***Patient Portal Web Access (my email):*_____**

STREET ADDRESS (if different from mailing): _____

Street City State

Zip

Driver's License #: _____Exp Date_____Driver License Issued in: __Nevada __Other: _____

Emergency Contact: _____ Relationship to Patient: _____Phone_____ Cell_____

Address: _____City_____State_____Zip_____

Primary Care Provider (Family MD): _____ Referring MD: _____

How did you hear about our practice? _Internet __ Ins. Panel __ Friend/Family __Lecture __Referral from: _____

_____

 *Today's Date:*_____

EMPLOYER INFO:

Employer Name: _____Occupation Title: _____

Work Address: _____

Street City State Zip

Work Phone #: _____Ext _____

SPOUSE'S INFORMATION:

Spouse Name: _____Spouse Birth Date: ____/____/_____ SSN: _____

Spouse Employer Name: _____Work Phone #: _____

Address_____City__ _____State _____Zip_____

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INSURANCE INFORMATION:

Medicare Patients: please write down Exact Name including your Middle Initial as on your Medicare Card

***Primary Insurance Company:*_____**

Phone # of Customer Service of Insurance (back of Ins. card) _____

***Subscriber/Insured Person Name:*_____ Relationship to Patient: _____**

Policy ID #: _____ Group ID#: _____Effective Date: _____

Secondary Insurance Company: _____Phone #: _____

*Name of Insured Person:*_____ *Relationship to Patient:* _____

Policy ID #: _____ Group ID#: _____Effective Date: _____

****If related to an accident:****

Date of Injury/Accident: _____

Name of Responsible Party: _____Phone: _____

Employment Related: _Yes __ No

If yes WCOMP Case: Case Manager: _____; ph #: _____

Accident Related: __Auto __Non Auto __No/Other

Who referred you? _____

Your Attorney Name _____ ph #: _____

I agree to the following:

1. **I will bring and inform to Dr Kenneth J. Shah all pertinent past medical records, tests, results and Rx medications.**
2. **I will inform Dr. Kenneth J. Shah of any changes in my address, insurance company or attorney.**
3. **I will inform Dr Kenneth J. Shah of my healthcare providers and pharmacy.**
4. **I allow the release of medical data to other organizations in order to adjudicate the claim.**
5. **I give consent to file a claim with my insurance carrier, attorney if lien, on my behalf. I allow the release of medical data to other organizations in order to adjudicate the claim and allow processing.**
6. **I give consent and permission to allow request and viewing of my prescription history from external sources.**
7. **I give consent to release medical records on my behalf from other providers.**
8. **I agree to the above information on this Patient Demographic Form.**
9. **It is my responsibility to update this form in case of any changes.**

_____**(Patient Signature/Date)**