LAST NAME: ______________________________ FIRST NAME: ___________________________ MI: _________

SOCIAL SECURITY #: ________________________________ DATE OF BIRTH: _______________________________

MALE: ☐FEMALE: ☐ MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐

EMPLOYED: YES ☐ NO ☐ IF YES WHERE: ____

HOW DID YOU HEAR ABOUT THE VEIN COMPANY? ____

HOME ADDRESS: ____ APT: _______________

CITY: ____ STATE: _________________ ZIP: ________________

EMAIL: _________________________________ WOULD YOU LIKE TO PARTICIPATE IN THE PATIENT PORTAL: YES ☐ NO ☐

HOME PHONE: ___________________ WORK PHONE: ____________________ CELL PHONE: __________________

EMERGENCY NAME: ______________________________________ RELATIONSHIP: _________________________

EMERGENCY PHONE: ________________________ DO YOU HAVE ADVANCED DIRECTIVES (LIVING WILL): YES ☐ NO☐

PRIMARY CARE PHYSICIAN: _________________________________ PHONE: ______________________________

REFERRING PHYSICIAN: ____________________________________ PHONE: ______________________________

RESPONSIBLE PARTY: SELF ☐ OR NAME: ____

ADDRESS: _______________________________ CITY: _______________________ STATE: _______ ZIP: _______

PHONE: ________________________________ RELATIONSHIP TO YOU: __________________________________

PRIMARY INSURANCE: ____

SUBSCRIBER NAME: ____ DATE OF BIRTH: ___________________

MEMBER ID: ____ GROUP: _________________________

SUBSCRIBER RELATIONSHIP TO PATIENT: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ _____________________________

SECONDARY INSURANCE: ____

SUBSCRIBER NAME: ____ DATE OF BIRTH: ___________________

MEMBER ID: ____ GROUP: _________________________

SUBSCRIBER RELATIONSHIP TO PATIENT: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ _____________________________

CONSENT TO RELEASE INFORMATION

PATIENT NAME: ____ DATE OF BIRTH: _________________________________

I GIVE THE VEIN COMPANY, LLC AND OFFICE STAFF PERMISSION TO DISCUSS MY MEDICAL CONDITION

(please list family members or friends only)

NAME: ____ PHONE: ____

RELATIONSHIP TO PATIENT: ____

NAME: ____ PHONE: ____

RELATIONSHIP TO PATIENT: ____

PLEASE REVIEW THE FINANCIAL AND OFFICE POLICIES:

- SELF PAY PATIENTS WILL PAY AT TIME OF SERVICE. COPAY'S ARE DUE AT THE TIME OF SERVICE.
- IF YOU HAVE A YEARLY DEDUCTIBLE YOU WILL NEED TO PAY AT TIME OF SERVICE. THE REMAINING BALANCE WILL BE DUE AFTER THE INSURANCE PROCESSING IS COMPLETE.
- IF PAYMENT PLANS ARE ESTABLISHED AND ARE NOT KEPT CURRENT, THE ACCOUNT WILL BE CONSIDERED FOR COLLECTIONS AND DISMISSED AS A PATIENT.
- THERE WILL BE A FEE OF $35.00 FOR RETURNED CHECKS. IF WE RECEIVE A RETURN CHECK, YOU WILL NO LONGER BE ABLE TO PAY WITH ANOTHER CHECK FOR PAYMENT. YOU WILL NEED TO PAY WITH CASH, MONEY ORDER OR CREDIT CARD.
- IF YOU DO NOT SHOW FOR AN OFFICE VISIT OR ULTRA SOUND APPOINTMENT OR CANCEL, YOU MAY BE CHARGED A NO SHOW FEE.
- IF YOU DO NOT SHOW FOR PROCEDURE OR CANCEL, YOU MAY BE CHARGED A NO SHOW FEE.
- IF YOU ARE HAVING A PROCEDURE THAT REQUIRES YOU TO WEAR COMPRESSION STOCKINGS, YOUR INSURANCE WILL NOT COVER COMPRESSION STOCKINGS, AND YOU WILL HAVE TO PURCHASE THEM OUT OF POCKET.
- IF YOU ARE HAVING SCLEROTHERAPY OF SPIDER VEINS, YOUR INSURANCE WILL NOT COVER COSMETIC PROCEDURES. YOU WILL BE RESPONSIBLE FOR PAYMENT AT TIME OF SERVICE.
- I AGREE THAT THE STAFF OF THE VEIN COMPANY MAY LEAVE A MESSAGE AT MY HOME OR CELL NUMBER.
- I AGREE THAT THE VEIN COMPANY MAY EMAIL, TEXT OR CALL (HOUSE OR MOBILE) FOR APPOINTMENT REMINDERS, BILLING, COLLECTION EFFORTS.

I authorize that all benefits from insurance companies or any other third-party payer will be paid directly to The Vein Company for services rendered by the healthcare providers employed by The Vein Company. I authorize this practice to act on my behalf and to provide any medical information about me to my Insurance provider in order to determine payment for services received from The Vein Company.

I have reviewed and understand the financial and office policies. I understand that I have been provided or offered with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notices and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED.

____ ______________________________

PATIENT SIGNATURE **DATE**

The Vein Company does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-379-0092 (TTY: 711)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-379-0092 (TTY: 711)

MEDICAL HISTORY

NAME: ____ DATE OF BIRTH: ________________

MALE: ☐ FEMALE: ☐ HEIGHT: ____________ WEIGHT: ___________

WHAT PROBLEMS ARE YOU SEEKING CARE FOR? ____

____

CIRCLE ALL ILLNESSES OR SYMPTOMS YOU HAVE BEEN TREATED FOR IN THE PAST OR PRESENT:

NONE	CHEST PAIN	HEART PALPATIONS	RECENT WEIGHT LOSS
ARTHRITIS	LIVER ISSUES	HEART ISSUES/LIST BELOW	SEIZURES
ASTHMA	COPD/EMPHYSEMA	EXAMPLE: HOLE IN THE HEART	SHORTNESS OF BREATH
BLADDER	DEPRESSION	HEPATITIS	STOMACH ISSUES/ULCER
BLEEDING/CLOTTING DISORDER	DIABETES	HIGH BLOOD PRESSURE	STROKE/TIA
BLURRED VISION	GASTROINTESTINAL ISSUES	HIGH CHOLESTEROL	THYROID ISSUES
CANCER	HEADACHES/MIGRAINES	HIV/AIDS	TUBERCULOSIS
RECENT WEIGHT GAIN	HEMORRHOIDS	KIDNEY ISSUES	OTHER

PLEASE LIST ANY SURGERIES/HOSPITALIZATION YOU HAVE HAD: ______________________________________

____

SMOKING: YES ☐ NO ☐ HOW MANY PER DAY? _________ ALCOHOL: YES ☐ NO ☐ HOW MANY GLASSES PER DAY/WEEK? ____________

[FEMALE ONLY] NUMBER OF PREGNANCIES: _____ NUMBER OF LIVE BIRTHS: ______ ARE YOU CURRENTLY PREGNANT OR BREAST FEEDING? ________

MEDICATION LIST

ARE YOU CURRENTLY ON ANY BLOOD THINNERS? (SUCH AS COUMADIN, WARFARIN, PLAVIX) YES ☐ NO ☐

DO YOU REGULARLY TAKE: ASPIRIN☐ IBUPROFEN ☐ TYLENOL ☐ ALEVE ☐ ANTIBIOTICS PRIOR TO DENTAL PROCEDURES ☐

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, OVER THE COUNTER AND PRESCRIBED.

MEDICATION NAME: DOSAGE (MORE ROOM NEEDED ADD ADDITIONAL PAPER)

____

____

____

____

ALLERGIES

ARE YOU ALLERGIC TO LOCAL ANESTHETICS SUCH AS EMLA/XYLOCAINE/TERTRACAINE? YES ☐ NO ☐ LATEX ALLERGY? YES ☐ NO ☐

PLEASE LIST ANY MEDICATION, FOOD, OR MEDICAL ADHESIVE ALLERGIES AND THE REACTIONS. ____________________________

____

VEIN SCREENING FORM ***PLEASE COMPLETE LEFT SIDE OF FORM ONLY ***

NAME: ______________________________ DATE OF BIRTH: ______________________________

VASCULAR HISTORY: DO YOU HAVE OR HAVE YOU EVER BEEN DIAGNOSED WITH?

VARICOSE VEIN PROBLEMS	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
PHLEBITIS (VEIN REDNESS/TENDERNESS)	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
BLOOD CLOTS	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
DEEP VEIN THROMBOSIS (DVT)	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐

DO YOU EXPERIENCE ANY OF THE FOLLOWING IN YOU LEG(S)?

ACHING/PAIN	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
HEAVINESS	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
TIREDNESS/FATIGUE	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
ITCHING/BURNING	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
SWELLING	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
CRAMPS	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
RESTLESS LEGS	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
THROBBING	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
SKIN OR ULCER PROBLEMS	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
HEMORRHAGING VEIN	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐

WHICH OF THE FOLLOWING DO YOU CURRENTLY DO TO IMPROVE YOUR LEG VEIN SYMPTOMS?

MEDICATION FOR PAIN/SYMPTOMS	YES ☐	NO ☐	WHAT? __________
ELEVATION OF LEGS	YES ☐	NO ☐	WHAT? __________
WEAR COMPRESSION STOCKINGS	YES ☐	NO ☐	WHEN? __________

FAMILY HISTORY: HAVE ANY OF YOUR FAMILY MEMBERS HAD?

VARICOSE VEINS	YES ☐	NO ☐	WHO?
VEIN STRIPPING	YES ☐	NO ☐	WHO?
BLOOD COAGULATION DISORDER	YES ☐	NO ☐	WHO?
BLOOD CLOTS	YES ☐	NO ☐	WHO?
STROKE, HEART ATTACKS	YES ☐	NO ☐	WHO?
PULMONARY EMBOLI	YES ☐	NO ☐	WHO?

VEIN TREATMENT HISTORY: HAVE YOU EVER BEEN TREATED FOR VARICOSE VEINS WITH?

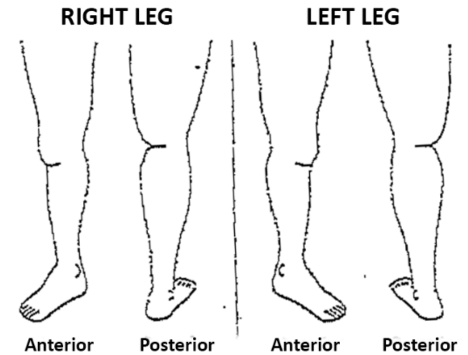
SCLEROTHERAPY	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
LASER THERAPY (SPIDER VEINS)	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
PHLEBECTOMY	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
VEIN STRIPPING SURGERY	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐
RF ABLATION	YES ☐	NO ☐	LEG: RIGHT ☐ LEFT ☐

PERSONAL ACTIVES LIST: DOES YOU WORK REQUIRE OR DO YOU?

PROLONGED STANDING PERIODS	YES ☐	NO ☐	
PROLONGED SITTING PERIODS	YES ☐	NO ☐	
DO YOU EXERCISE REGULARLY?	YES ☐	NO ☐	
ARE YOU A FREQUENT FLYER?	YES ☐	NO ☐	
DO YOU SMOKE?	YES ☐	NO ☐	
HAVE YOU HAD WEIGHT LOSS?	YES ☐	NO ☐	
PREGNANCIES?	YES ☐	NO ☐	HOW MANY? _____

THIS SIDE TO BE COMPLETED BY PROVIDER.

VEIN SCREENING (TO BE COMPLETED BY PROVIDER)



PHYSICAL EXAM CEAP CLINICAL SIGNS:

RIGHT LEG

No signs of venous disease __ Spider veins __
Visible varicose veins ___ Edema ___
Pigmentation __ Healed ulcers__ Active Ulcers __

LEFT LEG

No signs of venous disease __ Spider veins __
Visible varicose veins ___ Edema ___
Pigmentation __ Healed ulcers __ Active Ulcers __

CLINICAL ASSESSMENT:

Chronic Venous Insufficiency RIGHT ☐ LEFT ☐
Other: ________________ RIGHT ☐ LEFT ☐

TREATMENT PLAN:

Duplex Ultrasound RIGHT ☐ LEFT ☐
Medical compression stockings RIGHT ☐ LEFT ☐
Sclerotherapy RIGHT ☐ LEFT ☐
Other: ______________________________

Provider Signature: ______________________________
Date: ______________________________