310 N. STATE OF FRANKLIN STE 103

JOHNSON CITY, TN 37604

4 SHERIDAN SQUARE STE 102

KINGSPORT, TN 37660

PHONE 423-328-0163 FAX 423-491-8109

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 LEGACY VEIN CENTER/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.
- AFTER 6 MONTHS, CREDITS RANGING FROM $4.99 TO $0.01 WILL BE ADJUSTED OFF AS SMALL CREDIT ADJUSTMENTS.
- IF YOU DO NOT SHOW OR CANCEL FOR AN OFFICE VISIT OR ULTRA SOUND APPOINTMENT YOU MAY BE CHARGED A NO SHOW FEE.
- IF YOU DO NOT SHOW OR CANCEL FOR A PROCEDURE, YOU MAY BE CHARGED A $100 NO SHOW FEE; AND FOR A NO SHOW OFFICE VISIT OR ULTRASOUND YOU MAY BE CHARGED A NO SHOW FEE OF $50.
- 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, AND PATIENT PORTAL; IF YOU WISH TO NOT PARTICIPATE PLEASE INFORM US.

I authorize that all benefits from insurance companies or any other third-party payer will be paid directly to Legacy Vein Center/The Vein Company for services rendered by the healthcare providers employed by Legacy Vein Center. 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 Legacy Vein Center/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 acted in reliance thereon.

THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED.

____ ___________________________________

PATIENT SIGNATURE **DATE**

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

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

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

Chú ý: Nếu bạn nói tiếng Anh, Dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi 1-800-379-0092 (TTY: 711)

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MEDICAL HISTORY

NAME: ______________________________ DATE OF BIRTH: ______________

MALE: ☐ FEMALE: ☐ HEIGHT: ____________ WEIGHT: ____________ OCCUPATION: ______________

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 DISEASE	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? ______________

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

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 ☐
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? ___________

HOW DO YOUR SYMPTOMS IMPACT YOUR DAILY LIFE?

WORK	YES ☐	NO ☐
HOUSEHOLD CHORES	YES ☐	NO ☐
SLEEP	YES ☐	NO ☐
EXERCISE/MOBILITY	YES ☐	NO ☐
COOKING/GROCERY STORE	YES ☐	NO ☐

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? _____

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 OR HEART ATTACK YES ☐ NO ☐
WHO?______________________________

PULMONARY EMBOLI YES ☐ NO ☐
WHO?______________________________