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 OF LEGACY VEIN CENTER/THE VEIN COMPANY

- **PLEASE REMEMBER THAT BEING IN NETWORK WITH YOUR INSURANCE DOES NOT MEAN SERVICES ARE COVERED AT 100%, YOU WILL BE RESPONSIBLE FOR ANY APPLICABLE COPAYS/DEDUCTIBLES/COINSURANCE**
- SELF PAY PATIENTS WILL PAY AT THE TIME OF SERVICE. INSURED PATIENTS WILL PAY COPAYS AT THE TIME OF SERVICE
- IF PAYMENT PLANS ARE ESTABLISHED AND ARE NOT KEPT CURRENT, THE ACCOUNT WILL BE CONSIDERED FOR COLLECTIONS AND DISMISSED AS A PATIENT. WE ACCEPT ALL MAJOR CREDIT CARDS, CHECKS, CASH, AND CARE CREDIT.
- THERE WILL BE A FEE OF $35.00 ON RETURNED CHECKS. IF WE RECEIVE A RETURN CHECK, YOU WILL NO LONGER BE ABLE TO PAY WITH A CHECK FOR PAYMENT. YOU WILL NEED TO PAY WITH CASH, MONEY ORDER, OR CREDIT CARD.
- IF YOU DO NOT SHOW OR CANCEL FOR AN OFFICE VISIT OR ULTRASOUND APPOINTMENT, YOU WILL BE CHARGED A NO SHOW FEE OF **$50.00.**
- IF YOU DO NOT SHOW OR CANCEL FOR A MEDICAL/COSMETIC PROCEDURE, YOU WILL BE CHARGED A NO SHOW FEE OF **$100.00.**
- IF YOU HAVE FMLA/RETURN TO WORK/RESTRICTION FORMS TO BE COMPLETED, THERE WILL BE A **$10.00** CHARGE FOR EACH FORM.
- 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, YOU INSURANCE WILL NOT COVER COSMETIC PROCEDURES. YOU WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.
- I AGREE THAT THE STAFF OF THE VEIN COMPANY MAY LEAVE A MESSAGE AT MY HOME OR CELL NUMBER. PLEASE INFORM US IF YOU DO NOT WANT US TO LEAVE TEST RESULTS ON YOUR VOICEMAIL.
- I AGREE THAT THE VEIN COMPANY MAY EMAIL, TEXT, OR CALL (HOUSE OR MOBILE), AND SECURE MESSAGING VIA PATIENT PORTAL FOR APPOINTMENT REMINDERS, BILLING, AND COLLECTION EFFORTS.

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/The Vein Company. I authorize this practice to act on my behalf and to provide any medical information about me to my Insurance provider 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 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 1-423-328-0163 (TTY: 711)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-423-328-0163 (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 PALPITATIONS	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	HEMRRHOIDS	KIDNEY ISSUES	OTHER

PLEASE LIST ANY SURGERIES/HOSPITALIZATIONS YOU HAVE HAD: ______________________________________

____

SMOKING: YES☐ NO ☐ HOW MUCH? __________ HAVE YOU EVER SMOKED? ________ ALCOHOL: YES ☐ NO HOW MANY GLASSES PER DAY/WEEK? ____

[FEMALE ONLY] NUMBER OF PREGNANCIES: ______ NUMBER OF LIVE BIRTHS: _______ ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING? __________

MEDICATION INFORMATION

PHARMACY PREFERENCE________________________________ DO YOU GIVE TVC PERMISSION TO PULL YOUR MEDICATION LIST FROM THE PHARMACY LISTED? YES ☐ NO ☐

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

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

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, OVER THE COUNTER AND PRESCRIBED.
(YOU MAY USE A SEPARATE PIECE OF PAPER IF NEEDED)
MEDICATION NAME: DOSAGE

____

____

____

ALLERGIES

ARE YOU ALLERGIC TO LOCAL ANESTETICS SUCH AS EMLA/XYLOCAINE/TETRACAINE? YES ☐ NO ☐ LATEX ALLERGY? YES ☐ NO ☐
PLEASE LIST ANY MEDICATION, FOOD, OR MEDICAL ADHESIVE ALLERGIES AND THEIR REACTIONS: ______________________________

____

VEIN SCREENING FORM

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 YOUR LEGS?

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 ☐

IMMUNZATIONS: DATES WHEN YOU HAVE HAD:

FLU: ____________________

PNEUMOVAX: ____________________

PREVNAR 13: ____________________

COVID-19: 1. ____________________

2. ____________________

3. ____________________

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

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

PLEASE LIST ANY SYMPTOMS THAT MAKE YOUR LEG SYMPTOMS WORSE (I.E. SITTING, STANDING, EXERCISE, ETC)?

____

FAMILY HISTORY: HAVE ANY OF YOUR FAMILY MEMBERS HAD?

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

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

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

PERSONAL ACTIVITIES LIST: DOES YOUR WORK REQUIRE OR DO YOU DO ANY OF THE FOLLOWING:

PROLONGED STANDING	YES ☐ NO ☐
PROLONG SITTING	YES ☐ NO ☐
EXERCISE REGULARLY	YES ☐ NO ☐
FLY FREQUENTLY	YES ☐ NO ☐
WEIGHT LOSS	YES ☐ NO ☐