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, YOUR 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 based on 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 ARE CURRENTLY TREATED FOR OR HAVE BEEN TREATED FOR IN THE PAST:

CHEST PAIN/SHORTNESS OF BREATH	HEART PALPITATIONS	RECENT WEIGHT LOSS	NONE
ARTHRITIS	LIVER DISEASE	HEART ISSUES/LIST BELOW	SEIZURES
ASTHMA	COPD/EMPHYSEMA	EXAMPLE: HOLE IN THE HEART	DEGENERATIVE DISC
BLADDER/KIDNEY DISEASE	ANXIETY/DEPRESSION	HEPATITIS	NEUROPATHY
BLEEDING/CLOTTING DISORDER	DIABETES	HIGH BLOOD PRESSURE	STROKE/TIA
BLURRED VISION	GASTROINTESTINAL/ULCER	HIGH CHOLESTEROL	THYROID DISEASE
CANCER	HEADACHES/MIGRAINES	HIV/AIDS	TUBERCULOSIS
RECENT WEIGHT GAIN	HEMORRHOIDS	COVID 19	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: _____

_____

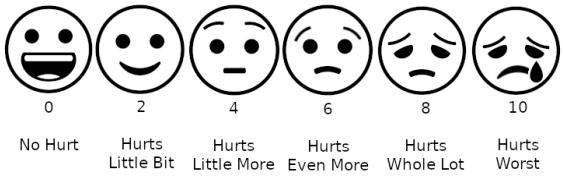
VEIN SCREENING FORM

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?
HOW LONG HAVE YOU HAD THESE SYMPTOMS? _____

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 ☐



RATE YOUR DISCOMFORT _____/10.

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 SITUATIONS WHICH 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 ☐

IMMUNZATIONS: DATES WHEN YOU HAVE HAD:
FLU:_____
PNEUMOVAX:_____
PREVNAR 13:_____
COVID-19: 1._____
2._____
3._____

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/LIFESTYLE INVOLVE ANY OF THE FOLLOWING:

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