VARICOSITY VEIN CENTER

BEST VEIN CARE of Huntsville
Founded by Varicosity Vein Center

DEMOGRAPHIC INFORMATION

LAST NAME: ____________________ FIRST NAME: ____________________ MI: ______

DATE OF BIRTH: _______________ (mm/dd/yyyy) SEX: _________ RACE: _____________

SOCIAL SECURITY #:__________________________ ETHNICITY: _________________

ADDRESS 1: ____________________________ ADDRESS 2: ________________________

CITY: _____________________ STATE:__________ ZIP: _______________

LANGUAGE: _______________ LANGUAGE COUNTRY:_________________________

MARITAL STATUS: ☐SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

☐PREGNANT (check if applicable) ☐ NURSING (check if applicable)

Whom may we thank for referring you to our practice? _______________________________________

CONTACT INFORMATION

HOME PHONE: _________________ WORK PHONE: __________________ EXT:_____

CELL PHONE: ______________________ EMAIL: ________________________________

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: ___________________ CONTACT LAST NAME: ___________________

CONTACT HOME PHONE: ___________________ CONTACT CELL PHONE: _________________

RELATIONSHIP TO PATIENT: ______________ CONTACT ADDRESS: ______________________

CITY: _____________________ STATE: _____________ ZIP: ___________________

FAMILY MEMBERS IN THE PRACTICE

_________________ (name) __________________ (relationship to patient)
_________________ (name) __________________ (relationship to patient)
_________________ (name) __________________ (relationship to patient)
_________________ (name) __________________ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: ___________________ PRACTICE NAME: _______________________

ADDRESS: _________________ CITY: _______________ STATE: _________ ZIP: _________

PHARMACY NAME: __________________________ PHARMACY PHONE: __________________

PHARMACY LOCATION: ____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: ______________________________ **Date:** ________________

RELEASE OF INFORMATION

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by ____________________________ in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to ____________________________ releasing information to me in the following manners:

VIA MAIL — PLEASE INITIAL

- ☐ OK TO MAIL TO HOME ADDRESS _______________
- ☐ OK TO MAIL TO WORK ADDRESS _______________

VIA HOME TELEPHONE

- ☐ OK TO LEAVE DETAILED MESSAGE ______________
- ☐ LEAVE CALL BACK NUMBER ONLY ______________

VIA WORK TELEPHONE

- ☐ OK TO LEAVE DETAILED MESSAGE ______________
- ☐ LEAVE CALL BACK NUMBER ONLY ______________

VIA FAX

- ☐ OK TO FAX TO: ___________________ ______________

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____________________________________ Date: ___________________

CANCELLATION & NO-SHOW POLICY

At Varicosity Vein Center, our goal is to provide quality treatment and care in a timely manner to all our patients. We schedule our appointments so that each patient receives the right amount of time to be seen by our providers and staff. A "no-show" or cancellation made with less than 48-hour notice significantly limits our ability to make the appointment available for another patient in need.

Please be courteous and call our office promptly if you are unable to attend your scheduled appointment. This time will be reallocated to someone who is in urgent need of treatment. Available appointments are in high demand and your early cancellation will give another person the opportunity to have access to timely care.

Surgeries

Patients who fail to show for their scheduled surgery appointment or did not notify the office **within 2 business days** of their scheduled surgery appointment time, shall be subject to a fee of **$250.00**.

As a courtesy, we send reminder text messages and/or make reminder calls in advance. Please note, if a reminder call or message is not received, the Cancellation & No-Show Policy remains in effect. Repeated missed appointments may result in termination of the physician/patient relationship.

If any appointment is cancelled by the physician or office as a medical necessity, then the patient is not subject to this charge. Insurance authorization denials are also an exemption of the fees.

These "No-Show/Cancellation" fees are not covered by insurance and are therefore the sole responsibility of the patient.

We appreciate your understanding of our need to follow a Cancellation & No-Show Policy to benefit our patients being seen in a timely and efficient manner.

Signature of Patient or Authorized Representative:

Printed Name: **Date:**

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: ________________________________ CO-PAY: ______________________

GROUP #: ________________________________ SUBSCRIBER #: _____________________________

INSURED FIRST NAME: _____________________ LAST NAME: _______________________ MI: _____

SOCIAL SECURITY #: __________________ DOB: ___________ RELATION TO PATIENT: __________

ADDRESS: ____________________ CITY: _____________________ STATE: _______ ZIP: ___________

PHONE #: ________________ EXT: _____

ADVANCED DIRECTIVE? ☐ YES ☐ NO WHERE IS IT FILED? _________________(what medical facility?)

INSURED EMPLOYED BY: _______________________ BUSINESS ADDRESS: ___________________

CITY: ______________ STATE ____ ZIP: __________ BUSINESS PHONE #: ______________________

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: ________________________________ CO-PAY: ______________________

GROUP #: ________________________________ SUBSCRIBER #: _____________________________

INSURED FIRST NAME: _____________________ LAST NAME: _______________________ MI: _____

SOCIAL SECURITY #: __________________ DOB: ___________ RELATION TO PATIENT: __________

ADDRESS: ____________________ CITY: _____________________ STATE: _______ ZIP: ___________

PHONE #: __________________________ EXT: ________

INSURED EMPLOYED BY: ____

BUSINESS ADDRESS: ___________________ CITY: ______________ STATE ____ ZIP: _____________

BUSINESS PHONE # : ___________________________________

EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

LAST DEGREE EARNED: ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: ________________________ BUSINESS NAME: ______________________________

BUSINESS PHONE: _____________________________________

DRIVERS LICENSE #: _____________________ STATE ISSUED: ____________

IS THIS AN ACCIDENT? DATE OF INJURY IS THIS A MOTOR VEHICLE ACCIDENT?

☐ YES ☐ NO _________________ ☐ YES ☐ NO

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT
By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _________________________________ **Date:** __________________

Today's Date:

Patient History Form

Name:_____________________________Date of Birth:_______________________Occupation:________________

Chief Complaint: Please describe the problems you are experiencing.

Current or past symptoms:

YES NO

Leg pain or discomfort
Legs feeling heavy
Leg cramps
Leg burning, itching
Leg swelling

YES NO

Restless legs
Enlarged leg veins
Skin color changes on the leg
Blood clots, DVT, or phlebitis
Leg ulcerations

Are any of these symptoms worse with prolonged standing or sitting?
Have you had any vein procedures in the past (surgical or cosmetic)?
Outcome: Previous Imaging Studies:

Do you use any of the following to manage your vein/leg symptoms?

YES NO

Medication (including over the counter) List:
Leg elevation How often:
Regular exercise How often:

Does your job require prolonged sitting or standing?
Do your symptoms affect any of your daily activities? This can include your job, social life, or even necessary tasks like grocery shopping. If yes, please describe:

Please list your current medications. If you do not take any medications, type "None":

Medication allergies. If you do not have any medication allergies, type "None":

YES NO

Smoker? __________Packs per day? _________Years?___________________
Former Smoker? When did you quit?__________________________________
Drink alcohol? If yes, how many times in the past year have you had 4 or more alcoholic drinks in a day?____

Male	Female
Height:	Weight:

Mother:	Alive Deceased	Father:	Alive Deceased

Women only—Date of last menstrual period

YES **NO**

Do you have a history of varicose veins of the vulva?
Do any of your leg/vein symptoms change with your period?
Do you have pain after intercourse?
Do you have pelvic pain?
If yes, do your symptoms get better after lying down? **YES** **NO**

Family History: Have any of your family members had:

YES **NO**

Vein stripping or vein surgery?	If yes, who?
Varicose veins?	If yes, who?
Blood coagulation disorder?	If yes, who?
Blood clots?	If yes, who?
Stroke?	If yes, who?
Heart attack?	If yes, who?
Pulmonary embolism?	If yes, who?

List any past surgeries and the approximate year:

Please check if you have any of the following:

High blood pressure	History of heart attack	Chest pain
Heart murmur	Irregular heart beat	Artificial heart valve
Peripheral vascular disease	Congestive heart failure	Diabetes
Kidney disease	Cancer	Epilepsy/Seizure
Arthritis	Mental illness	Emphysema
Asthma	Shortness of breath	Artificial Joints
Wheezing	Stroke	High Cholesterol
Thyroid disease	Seasonal allergies	Bleeding disorder
Gastrointestinal disease	Liver disease/Hepatitis	HIV

- **Date of last flu vaccine:**
- **Date of last pneumonia vaccine:**
- **Date of last mammogram (women):**
- **Date of last colonoscopy:**

Clinician signature:____**Date:**__________________