VeinSolutions & Demeter Surgical Demographic Information DATE:

NAME: ____

STREET ADDRESS: __________________________________

____

CITY/STATE/ ZIP CODE: _____________________________

☐ HOME PHONE #: _________________________________

☐ CELL PHONE #:__________________________________

☐ WORK PHONE #: _________________________________

Check one number above which we should call to confirm your appointment.

BIRTHDATE: ________________

GENDER: ☐ FEMALE ☐ MALE

SOCIAL SECURITY #:

____

MARITAL STATUS: ☐ MARRIED

☐ SINGLE ☐ WIDOWED ☐ OTHER

EMPLOYMENT STATUS:

☐ EMPLOYED/FULL-TIME ☐ EMPLOYED/PART-TIME ☐ NOT EMPLOYED ☐ RETIRED

☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT

OCCUPATION: ____________________________ EMPLOYER: ____________________________

FAMILY PHYSICIAN: ________________________________ PHONE #:______________________

REFERRING PHYSICIAN (IF ANY): _____________________ PHONE #:______________________

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ REFUSE TO REPORT

LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER

RACE: ☐ ASIAN ☐ AFRICAN AMERICAN ☐ WHITE ☐ HISPANIC ☐ OTHER ______________

EMAIL ADDRESS ____

Would you like to be signed up for our Patient Access Portal: (Please Circle) YES NO

The patient access portal is an online service that provides you a secure method of accessing and updating your information.

PHARMACY INFORMATION

PHARMACY NAME: ______________________PHONE #:_____________________________

ADDRESS: ____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME: __________________ PHONE #:_____________________________

RELATIONSHIP: ________________________DOB: ____________________________

SPOUSE/GUARANTOR NAME: ____

ADDRESS (IF DIFFERENT): ____

CITY: _____________________ STATE: _______ ZIP CODE: ______________

HOW DID YOU HEAR ABOUT US? ☐ Television ☐ Radio ☐ Newspaper ☐ Personal ☐ Internet ☐ Physician Referral

(Name of person who referred you to us) ________________________________

INSURANCE INFORMATION

PRIMARY INSURANCE:	SECONDARY INSURANCE:
POLICY HOLDER NAME:	POLICY HOLDER NAME:
(Address if Different from Patient)	(Address if Different from Patient)
POLICY HOLDER DOB:	POLICY HOLDER DOB:
POLICY ID:	POLICY ID:
POLICY GROUP NUMBER:	POLICY GROUP ID:
EMPLOYER NAME:	EMPLOYER NAME:
EFFECTIVE DATE:	EFFECTIVE DATE:

HIPAA RELEASE / MEDICAL INFORMATION RELEASE FORM

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to the party/parties listed below:

Spouse ____

Child(ren) ____

Other ____

The Release of Information will remain in effect until terminated by me in writing.

MESSAGES: Please call: Home: ____________ Work: _______________ Cell: ________________

The best time to reach me is ____________ to ____________

If you are unable to reach me:

__ You may leave a detailed message. ___ Please leave a message asking me to return your call.

__ Other: (explain) ____

Signature:_________________________ Date:______________

I do not authorize VeinSolutions & Demeter Surgical to release information to anyone other than myself.

Signature __________________________ Date __________

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN WHERE INDICATED.

Payment Policy: I understand that if this office may be a participating provider with my insurance, and if I am responsible for any deductible or copayment, I am required to pay it at the time the services is rendered. If this office is not a participating provider with my insurance, I understand that I am expected to pay my bill IN FULL at the time the service is rendered. If I am unable to do so, arrangements must be made in advance and with the provider's approval. VeinSolutions & Demeter Surgical, out of courtesy, will submit a claim to my insurance company on my behalf. I agree to assign and authorize payment made directly to VeinSolutions & Demeter Surgical of all insurance benefits. I understand it is mandatory to notify my health care provider of any other party who may be responsible for paying for my treatment. I understand that my services are not required to be submitted to my health plan if I opt to pay out of pocket for services rendered.

Release of Information: I hereby authorize this office to furnish information from my medical record to any health care provider whom he deems necessary to provide continuity of my care. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, any information needed for any Medicare of other insurance claim. I permit a copy of this authorization to be used in place of the original and note that I may withdraw my authorization at any time via written notification to the parties involved.
I understand that I am financially responsible for any balance not covered or payable by my insurance plan.

SIGNATURE ________________________________ DATE ________________________

Pharmacy Release: I hereby authorize this office to retrieve information concerning my prescription medications from the National Pharmacy Database, including, but not limited to all medications which have been electronically prescribed to me or filled from a written order from other medical providers.

SIGNATURE _________________________________DATE ________________________

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices:
I acknowledge that I have been provided access to review the HIPAA Notice and Privacy Practices. I also acknowledge that I can obtain a personal copy of this document upon request.

SIGNATURE ________________________________ DATE ________________________

VeinSolutions
Leaders in Cosmetic & Therapeutic Vein Care

Patient Medical / Surgical History Form - VeinSolutions & Demeter Surgical

Patient name: ____ DOB: _____/_____/_________

Family physician: ______________________________ Referring physician: _____________________________

❶ **CURRENT MEDICATIONS** (please list name & dosage of meds): ____________________________________

____

____

❷ **ALLERGIES**: ☐ None ☐ Latex ☐ PCN ☐ sulfa ☐ Other ____
Allergic Reaction: ____

❸ **PERSONAL MEDICAL HISTORY** (please check if you have been diagnosed with any the following):

☐ High blood pressure
☐ History of stroke
☐ History of heart attack
☐ Hepatitis
☐ Bleeding problems
☐ Heart disease (specify) ____________________
☐ Lung disease (specify)____________________
☐ Bowel disorder (specify)___________________
☐ Major accident _________________________
☐ Other_______________________________
☐ Diabetes
☐ Kidney disease
☐ Arthritis
☐ Difficulty with anesthetics
☐ HIV/AIDS
☐ History of cancer (***please specify what type/ location***) ____

❹ **SURGICAL HISTORY** (please list procedure name & approximate date performed): ______________________

____

____

❺ **HOSPITALIZATION**: Have you been admitted to a hospital for any reason in the last 12 months?

☐ YES ☐ NO If yes, where were you hospitalized? ____

For what medical issue(s) were you admitted? ____

❻ **FAMILY MEDICAL HISTORY** (Please check medical conditions applicable to family & ***specify what family member***):
☐ Heart ___________________________________
☐ High blood pressure _______________________
☐ Cancer _________________________________
☐ Diabetes ____________________________________
☐ Lung disease ________________________________
☐ Other ______________________________________
STATUS: Father ☐ Alive ☐ Deceased Mother ☐ Alive ☐ Deceased

❼ **SOCIAL HISTORY**:
Do you smoke cigarettes or use other tobacco products? ☐ YES ☐ NO / If yes, how much? __________________
Do you consume alcohol? ☐ YES ☐ NO / If yes, how much? __________________
Do you exercise regularly? ☐ YES ☐ NO / If yes, list type ______________________

❽ **FOR FEMALE PATIENTS**:
Are you pregnant? ☐ YES ☐ NO ☐ UNSURE
# of pregnancies: _______ / # of children: _________
Date of last menstrual period (LMP)? ____/____/_______
Are you currently breastfeeding? ☐ YES ☐ NO

Date of last mammogram? ____/____/_______ Result? ☐ Normal ☐ Abnormal

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VITALS: Ht ______” Wt _______# BP ___________ HR _________ RR _________ O_2 _________%

Revised 10/10/16 bkd