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

New Patient Venous History Form - Vein Solutions & Demeter Surgical

IT IS IMPORTANT THAT THIS FORM IS FILLED OUT COMPLETELY. THANK YOU. **DATE:_____/_____/_____**

NAME: _____ **DOB:** _____/_____/_____ **AGE:** _____ **GENDER:** □ **FEMALE** □ **MALE**

1 REASON FOR VISIT: □ Varicose (bulging) veins □ Spider veins □ Other: _____

If you have varicose or spider veins, when did they occur?:

At age: _____ Before pregnancy?: □ YES □ NO After pregnancy?: □ YES □ NO After trauma?: □ YES □ NO

After taking birth control or hormonal drug therapy?: □ YES □ NO Other: _____

Please describe your expectations of treatment: _____

_____

2 PAST TREATMENT:

Have you ever been treated for the above problem(s)?: □ YES □ NO If so, when?: _____

By whom?: _____ What method?: □ Sclerotherapy □ PhotoDerm □ Laser □ Surgery

Have you ever worn support hose?: □ YES □ NO Length of time support hose worn?: _____weeks/years

Do you use medication (prescriptions OR over-the-counter) to relieve your leg pain?: □ YES □ NO

If yes, please list:_____ How do you take the medication?: □ daily basis □ as needed

3 PLEASE COMPLETE THE FOLLOWING SECTION REGARDING SYMPTOMS:

*Do you now have:	RT LEG	LT LEG
- pain in your thigh?	□	□
- pain in your calf?	□	□
- pain in your foot?	□	□
- ulcer on your legs?	□	□
- fatigue in your legs?	□	□
- swelling in your legs?	□	□
*Symptoms get worse with:		
- standing	□	□
- heat	□	□
- before/during menses	□	□

*The leg pain is better with:	RT LEG	LT LEG
- elevation of the leg	□	□
- compression hose	□	□
- medication	□	□
- exercise/walking	□	□
*My symptoms feel like:		
- aching/tiredness/heaviness	□	□
- cramping	□	□
- burning	□	□
- numbness	□	□
- itching	□	□

Do your symptoms, caused by your varicose and/or spider veins, interfere with your work or other daily activities?

□ YES □ NO COMMENTS _____

_____

4 PATIENT HISTORY:

Please check if you have a history of:

□ Phlebitis □ Leg ulcers □ Pulmonary embolism □ Use of anticoagulants (Coumadin/Heparin)

□ Blood clots □ Leg injury □ Leg bone fracture □ Family history of varicose/spider veins

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 □ Heart disease (specify) _____ □ Diabetes
□ History of stroke □ Lung disease (specify)_____ □ Kidney disease
□ History of heart attack □ Bowel disorder (specify)_____ □ Arthritis
□ Hepatitis □ Major accident _____ □ Difficulty with anesthetics
□ Bleeding problems □ Other_____ □ 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 _____ □ Diabetes _____
□ High blood pressure _____ □ Lung disease _____
□ Cancer _____ □ 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 Date of last menstrual period (LMP)? ____/____/_____
# of pregnancies: _____ / # of children: _____ Are you currently breastfeeding? □ YES □ NO

Date of last mammogram? ____/____/_____ Result? □ Normal □ Abnormal

VITALS: Ht _____" Wt _____# BP _____ HR _____ RR _____ O_2 _____%