PATIENT INFORMATION

Date: ____________________

Name of Referring Physician: ______________________________

(Please Print)

Name Last First Middle	Social Security Number - -	Marital Status S M W D	Sex M F	Birth Date	Age

Street Address	City/State	Zip	Home Phone # ( )	Cell Phone # ( )

Patient's Employer	Occupation (Indicate if student)	Buisness Phone # ( ) Ext #

Employer's Street Address	City/State	Zip

Spouse's Name	Social Security Number - -	Date of Birth

Spouse's Employer	Occupation (indicate if student)	Business Phone # Ext#

Employer's Street Address	City/State	Zip

Name of friend or relative not living with you: ____________________ Relationship: ______________

Address: ______________________________ City/State/Zip: ___________________________

Phone Number: _________________________

Person Responsible for Payment, If not above:	Street Address, City, State	Zip	Home Phone # ( )

Medicare# ❑	Effective Date	Insurance Company ❑	Effective Date

Primary Insurance	Name of Holder & Date of Birth	Policy number	Group number
Secondary Insurance	Name of Holder & Date of Birth	Policy number	Group number

Name of Primary Care Physician (PCP)	Office number ( )

Other (name of insurance company)	Effective Date	Policy number	Group number

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.

_________________________________ _____________________

Signature of Patient, Guardian OR Responsible Party Date of Signature

ASSIGNMENT OF INSURANCE BENEFITS AND / OR RELEASE OF INFORMATION AUTHORITY

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing, my insurance company, and/or it's intermediaries and carriers, any information needed for this or a related insurance claim. I permit a copy of this authorization be used in place of the original and I request payment of medical insurance benefits be paid either to myself or to THE VARICOSE VEIN CLINIC OF TEXAS for any services furnished to me by their physicians.

_________________________________ _____________________

Signature of Patient, Guardian OR Responsible Party Date of Signature

Please Note: **BOTH** signature spaces must be signed in order for us to file with your insurance.

VEINTEC VARICOSE VEIN CLINICS

Patient Name: ______________________________ Email: ____________________________ Date: ______

Referred By: ________________________________ Years with Varicose/Spider veins : __________

Primary Care Physician: ______________________ Number: ____________________________________

Your Pharmacy: Name ________________________ Number: ____________________________________

Vein / Skin Conditions: (Please check all that apply)

- ☐ None
- ☐ Small Red "Spider" Veins
- ☐ Diagnosed with Vein Disease
- ☐ Purple Veins
- ☐ Skin Discoloration
- ☐ Purple Vein Networks
- ☐ Flat, Blue-green Veins
- ☐ Abdominal Veins
- ☐ Bulging Veins
- ☐ Vaginal Veins
- ☐ Chest or breast veins
- ☐ Facial Veins
- ☐ Ankle Sores

Other: (Please Describe) ____

Leg and Ankle Problems: (Please Explain Symptoms marked Yes)

Aches	☐ Yes	☐ No	____________________
Pain	☐ Yes	☐ No	____________________
Swelling	☐ Yes	☐ No	____________________
Fatigue	☐ Yes	☐ No	____________________
Heaviness	☐ Yes	☐ No	____________________
Itching	☐ Yes	☐ No	____________________
Cramps	☐ Yes	☐ No	____________________
Restlessness	☐ Yes	☐ No	____________________

Other: ____

Do any of your symptoms affect your daily living: YES / NO

If you answered yes to above question , how: ____

Methods Used to Relieve Leg Discomfort:

- ☐ No Discomfort
- ☐ Leg Elevation
- ☐ Flexion / Extension of Feet
- ☐ Walking
- ☐ Warm Soaks
- ☐ Aspirin
- ☐ Wraps
- ☐ Ibuprofen
- ☐ Tylenol
- ☐ Exercise
- ☐ Compression Hose
  Type: ____________ How long have you used them? ____
- ☐ Cold Packs
- ☐ Other: ____

Family History of Spider/Varicose Veins:

- ☐ None
- ☐ Mother
- ☐ Father
- ☐ Son/Daughter
- ☐ Grandparent
- ☐ Sister/Brother
- ☐ Aunt/Uncle
- ☐ Other: ________________________

Family History of Deep Thrombosis, Stroke, or Clotting Disorders:

- ☐ None
- ☐ Mother
- ☐ Father
- ☐ Son/Daughter
- ☐ Grandparent
- ☐ Sister/Brother
- ☐ Aunt/Uncle
- ☐ Other: ________________________

VEINTEC VARICOSE VEIN CLINICS

HISTORY & PHYSICAL

Conditions Patient Had/Has: ☐ Diabetes (Type 2) ☐ Diabetes (Type 1)

☐ None
☐ Anemia
☐ Ankle Skin Changes
☐ Atherosclerosis
☐ Bleeding/Blood Disorder
☐ Chest pain or Discomfort
☐ Constipation
☐ Crohn's
☐ Disease/IBS
☐ Other: ______

☐ Easy Bruising
☐ Heart Disease
☐ Hepatitis
☐ High Cholesterol
☐ HIV/AIDS
☐ Trauma to legs
☐ Kidney Disease
☐ Liver Disease
☐ Hypertension (high blood pressure)

☐ Lupus
☐ Migraine Headaches
☐ Mitral Valve Prolapse
☐ Pulmonary Embolus
☐ Rupture of a Vein
☐ Superficial thrombophlebitis
☐ Leg Ulcers
☐ Deep Vein Thrombosis/Clot

Current Medical Situation:

Any allergy to medications or other substances: ☐ Yes ☐ No

If yes, please list: ______

Do you have any current illnesses: ☐ Yes ☐ No

If yes, please describe: ______

Please list any current medications, vitamins, or herbal supplements that you are taking:

______ ______ ______

______ ______ ______

______ ______ ______

Are you now, or are you planning to be pregnant? ☐ Yes ☐ No

Are you currently breast feeding? ☐ Yes ☐ No

Do you have discomfort around your menses? ☐ Yes ☐ No

How many pregnancies have you had? ______ How many miscarriages have you had? ______

Social History: Occupation: ______

On feet for long periods of time? ☐ Yes ☐ No If yes, in what capacity: ______

Height: ______ Weight: ______

Smoker: ☐ Yes ☐ No Smoke per day: ______ Alcohol Use: ☐ Yes ☐ No Drinks per day : ______

VEINTEC VARICOSE VEIN CLINICS

History & Physical

Past Surgeries: (Check all that apply & describe)

- ☐ Abdominal ______________________________
- ☐ Heart ______________________________
- ☐ Head and Neck ______________________________
- ☐ OB/GYN ______________________________
- ☐ Breast ______________________________
- ☐ Orthopedic ______________________________
- ☐ Other ______________________________

Previous Vein Treatment:

Treatment	Leg	Date	Provider
☐ Stab Phlebectomy	Leg: ☐ Rt ☐ Lt ☐ Both	Date: ________	Provider: ________
☐ Varicose Vein Injections	Leg: ☐ Rt ☐ Lt ☐ Both	Date: ________	Provider: ________
☐ Endovenous Laser Ablation	Leg: ☐ Rt ☐ Lt ☐ Both	Date: ________	Provider: ________
☐ Ligation and/or Stripping	Leg: ☐ Rt ☐ Lt ☐ Both	Date: ________	Provider: ________
☐ Radio-frequency Ablation	Leg: ☐ Rt ☐ Lt ☐ Both	Date: ________	Provider: ________
☐ Sclero (reticular vein) Injection	Leg: ☐ Rt ☐ Lt ☐ Both	Date: ________	Provider: ________
☐ Spider vein Injections	Leg: ☐ Rt ☐ Lt ☐ Both	Date: ________	Provider: ________
☐ Spider vein Laser Therapy	Leg: ☐ Rt ☐ Lt ☐ Both	Date: ________	Provider: ________

What were the results of the above treatments: ______________________________

Other:

What would you most like to correct about your legs? ______________________________

Veintec Varicose Vein Clinic

Disclosure of Medical/Financial Information to Friends or Family

Name of Patient: ____
Date of Birth: ____
Address of Patient: ____
____

I, the undersigned, hereby authorize Veintec Varicose Vein Clinic to disclose information from my medical or financial record to the following people. I understand that Veintec Varicose Vein Clinic will disclose both medical and financial information to my spouse unless I have placed his/her name in the list below with the notation "EXCEPTION" written beside the listing.

Name: ____
Relationship: ____
Contact Information: ____
Type of Information (Circle) **MEDICAL** **FINANCIAL** **BOTH**

Name: ____
Relationship: ____
Contact Information: ____
Type of Information (Circle) **MEDICAL** **FINANCIAL** **BOTH**

(ADDITIONAL PERSONS MAY BE LISTED ON THE OTHER SIDE IF NECESSARY)

CONSENT FOR PHONE MESSAGES TO BE LEFT ON LISTED NUMBERS IN VEINTEC SYSTEM.

______ Yes, I give consent to allow a brief messages to be left on the phone number(s) listed in the Veintec system.

______ No, I do not give consent to allow a brief messages to be left on the phone number(s) listed in the Veintec system.

This authorization is given freely with the understanding that:

1. I may revoke this authorization at any time, but not retroactively.
2. The facility, its employees, officers, and physicians are hereby released form any legal responsibility or liability for disclosure of the information I authorized previously.

______________________ Patient's Name Printed	______________________ Date
______________________ Patient's (or personal representative's) Signature	______________________ Social Security Number (ID purposes only)
______________________ Witness Printed Name	______________________ Date
______________________ Witness Signature	______________________ Personal Representative's Authority