



BASIC PATIENT INFORMATION

Please enter the information required, print, and bring with you to our office.

Patient's Social Security Number: _____ - _____ - _____
Name of Patient First: _____ Middle: _____ Last: _____
Birthdate: _____ Gender: M F
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (____) _____ Work Phone: (____) _____

PATIENT'S RELATIONSHIP TO INSURANCE POLICY HOLDER

Self Spouse Guardian/Parent ***Insurance Holders Date of Birth: ____/____/20__

Please present your insurance card and driver's license to the front desk receptionist when returning this form and inform the receptionist of any copay.

ADDITIONAL PATIENT INFORMATION

Marital Status: Single Married Divorced Separated Widowed
Patient's Employment Status: Full Time Part Time Retired/None
Student Status(If Applicable): Full Time Part Time Retired/None
Did you bring a written referral from your Referring Physician? Yes No
Referring Physician: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____
Home Phone: (____) _____ Work Phone: (____) _____
Street Address: _____
City: _____ State: _____ Zip Code: _____

FINANCIAL RESPONSIBILITY AGREEMENT

I/We hereby authorize **West End Surgical, Inc./Richmond Vein Center** to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We authorize payment of medical benefits to **West End Surgical, Inc./Richmond Vein Center** and further understand that should my account have to be referred to an attorney for collection that I am responsible for all fees and costs incurred therein. I/We hereby authorize **West End Surgical, Inc./Richmond Vein Center** to act on my behalf in accessing hospital medical records when and if needed.

Patient or Guardian Signature

Date

VEIN TREATMENT QUESTION SHEET

Name: _____

Age: _____ Gender: M F Doctor's Name: Gould Chen

Directions: Please answer the following questions, trying not to leave any blank spaces.

PAST MEDICAL HISTORY

1. Have you ever been in the hospital as a patient?.....Yes No
If Yes, for what reason? _____

2. Have you ever had surgery?.....Yes No
If Yes, what type of surgery and when? _____

3. Have you ever had vein stripping surgery?..... Yes No
If Yes, when and which leg? _____

4. Have you ever had vein injections?.....Yes No
If Yes, when, which leg and where on the leg? _____

5. Are you presently under the care of a physician?Yes No
If Yes, for what illness or purpose? _____

6. Do you have Heart Disease?Yes No
Lung Disease?.....Yes No
High Blood Pressure?.....Yes No
Hepatitis?.....Yes No
Arthritis?.....Yes No
Leg Ulcer(s)?.....Yes No

7. Have you ever had a blood clot?Yes No
If Yes, which leg and when: _____

8. Have you ever had phlebitis (inflammation of a vein)?Yes No

CHILD REARING HISTORY

- 1. Do you think that you are presently pregnant?..... Yes No
- 2. How many times have you been pregnant?..... Yes No
- 3. Do you intend to have any more children?..... Yes No
- 4. Are you presently breast-feeding?..... Yes No
- 5. Have you ever miscarried?..... Yes No

FAMILY HISTORY

- Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?
- Father..... Yes No
 - Mother..... Yes No
 - Brother(s)..... Yes No
 - Sister(s)..... Yes No
 - Other?

YOUR VEIN HISTORY

- 1. Do you experience any of the following?
 - a. Aching/pain in your legs..... Yes No
 - b. Heaviness..... Yes No
 - c. Tiredness/fatigue..... Yes No
 - d. Itching/burning..... Yes No
 - e. Swollen ankles..... Yes No
 - f. Leg cramps..... Yes No
 - g. Restless legs..... Yes No
 - h. Throbbing..... Yes No
 - i. Other
- 2. Have your veins gotten worse in recent months?..... Yes No
- 3. Do you elevate your legs to relieve discomfort?..... Yes No

4. Do you have any problem with walking?.....Yes No
If yes, how does it affect you?_____

5. Do you stand much at work?.....Yes No
at home?.....Yes No

6. How does this standing affect your legs?

7. Do you smoke?.....Yes No
If yes, how many packs per day?_____

8. Have you ever had your veins evaluated before?.....Yes No
If so, when and where?_____

9. Have you ever had any test(s) done on your veins?.....Yes No

CURRENT MEDICAL HISTORY

1. Do you have any allergies (medicines, food, pollen, etc.)?.....Yes No
If yes, please list them and briefly describe your reaction (e.g. rash, hives, shortness of breath, etc.):

2. Are you allergic to shrimp, shellfish or any form of iodine, IVP dye?.....Yes No

3. Are you presently taking any medication including prescription and/or non-prescription (over-the-counter) medicines (aspirin, vitamins)?.....Yes No

4. Do you take any blood-thinning medications?.....Yes No
If yes, please list name(s):_____

4. Are you taking hormones or birth control pills?.....Yes No
If yes, please list name(s):_____

WRITTEN ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, _____ (Please type patient name) have been provided a copy of the medical Practice's Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the medical Practice if I do not understand any information contained in the Notice of Privacy practices.

PATIENT/GUARDIAN SIGNATURE

DATE

RELATIONSHIP TO PATIENT

BASIC PATIENT INFORMATION, CONTINUED

DISCLOSURES TO FAMILY MEMBERS AND FRIENDS

Place on inside flap of medical record.
Patient DOES NOT have to Sign

I have explained to the patient, _____, that disclosures may be made to family and friends related to the patient's health or as needed for payment of health care services, Physicians or Medical Facility (i.e. hospital or surgery center). I have explained that we will only disclose information relevant to the current treatment. Our patient has agreed that we may disclose health care information to: (check all that apply)

Release information to **NO ONE**

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

***** BELOW IS FOR STAFF USE ONLY *****

Although the patient was not available (or I could not discuss with the patient because of the patient's incapacity or an emergency circumstance), I felt that it was in the best interest of the patient to make a disclosure regarding the patient's health care status or payment for health care services to:

NAME (optional)	RELATIONSHIP	DATE OF DISCLOSURE	COMMENTS	EMP. INITIALS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____