PATIENT INFORMATION:

Name:___________________________________ Date of Birth:___________ Sex:________
Language: ________________ Race: _______ Ethnicity: ______________________
Home Address: _________________________ City: ________________ State: _____ Zip: ______
Home Phone #:____________ Marital Status: _________ SS #:_________________
Employer: ________________________ Work #:______________________________
Work Address: __________________________ City: ____________________ State: _____ Zip: ______
Cell Phone #:_____________________ Email*:____________________________
Best Contact: Home / Work / Cell / Email Voice Mail: Y - N_____
Emergency Contact: ____
Name Phone

*By providing your email, you agree to receive updates, news, and general information from Alliance Vein Center. We respect your right to privacy and will not share your information.

INSURANCE INFORMATION:

(Primary)
Insurance Co.:_____________________
Policy #:_________________________
Group #:_________________________
Name of Guarantor:_________________
Insured's Date of Birth:______________
Insured's ID or SS:_________________

Employer (if group policy):____________

(Secondary)
Insurance Co.:______________________
Policy #:__________________________
Group #:__________________________
Name of Guarantor:_________________
Insured's Date of Birth:______________
Insured's ID or SS:_________________

Employer (if group policy):____________

ASSIGNMENT OF BENEFITS

In consideration for the services rendered, I hereby irrevocably assign and transfer to Alliance Vein Center, and to any physician providing services, all rights, title and interest, to the benefits payable by any and all third party payers that are or may be liable for the services rendered, to the patient. This irrevocable assignment and transfer shall allow Alliance Vein Center, or those physicians, to pursue any such right of recovery. Even though I have made this assignment, I understand that Alliance Vein Center is a contracted provider with BCBS, Humana, Cigna & Medicare. We are not contracted with the remaining insurance providers. If we are not a contracted provider we will bill your services as an out of network provider. I understand that Alliance Vein Center, has the right to demand payment in full from me and the liability shall remain joint and several as between myself and all guarantors and third party payors, and I am responsible for payment for any charges not paid for me on my behalf

____
Signed (Insured Person) Date

RELEASE OF INFORMATION

I hereby authorize Alliance Vein Center to release any information acquired in the course of my examination or treatment.

____
Signed (Patient) Date

06/2016

Patient Name: ___________________________________ Age: ___________
Primary Care Doctor: ____________________ Referring Physician: ____________________
Cardiologist Doctor: ____________________________
Pharmacy: ______________________________ Pharmacy Phone: (______) ______-________

Vascular History

Place an "x" if you have any of the following:

__Red/purple spider veins __Skin discoloration below knee
__Abdominal veins __Bulging veins __Other:______________
__Leg ulcers/Open wounds __Diagnosed with vein disease ______________________

Years with varicose veins/spider veins_______
Years with venous ulcers/open wounds_______

Place an "x" if you have any of the following:
__Ache or hurt __Swelling __Itching
__Become restless __Ankle skin changes __Heaviness __Pelvic Pain
__Cramping __Other_________
__Bleeding from veins __Burning ________________

Please check any factors that **aggravate** your leg discomfort:
__Prolonged standing __Exercise __Sexual Intercourse
__ Prolonged sitting __Tender to touch __Other: ____________ __Around/during Menstrual Cycle __ Pregnancy ____________________

How do your symptoms affect your daily activities? ____________________________________
____

Please check any methods you have used to **relieve** your leg discomfort:

__No discomfort
__Compression hose/Leg wraps
__Exercise
__Leg elevation
__Warm soaks/heating pad
__Cold packs
__Massage
__Pain medications
__ Other:_____________

Have you ever worn compression stockings? Yes ☐ No ☐

If so, Stockings prescribed by: ________________ When? __________ How long? ___________

Have you been treated for your leg veins before? Yes ☐ No ☐

By whom? ______________________When? __________________________

- If so, By which of the following methods :

__Cosmetic injections
__Radiofrequency closure
__ Laser for spider vein
__Stripping
__Ambulatory Phlebotomy
__Ultrasound guided injections
__Laser catheter ablation
__ Ligation:
__Other:_______________
__Unknown

What was the outcome? ____

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

____

Are you currently on or have been prescribed blood thinners? Yes ☐ No ☐

- **If yes, for how long? ______________________________**

Current Medication(s) (no need to record dosage)

Allergies to medications **Reaction**

Past Medical History

Place an "x" if you have any of the following medical illnesses:

__COPD	__Blood transfusions	__High cholesterol
__HIV or AIDS	__Clot in lungs (PE)	__Stroke
__Arthritis	__Clot in legs (DVT)	__Kidney problems
__Asthma	__Depression	__Lupus
__Hole in your heart	__Diabetes	__Hepatitis B
__Bleeding disorder	__Dialysis	__Hepatitis C
__Cancer	__Heart attack (MI)	__Thyroid disease
__Pace Maker	__High blood pressure	__Migraines

Please list any surgeries that you have had:

Please indicate if you have a **FAMILY** history of varicose or spider veins?

__Mother __Father __Maternal Grandparents
__Siblings __Children __Paternal Grandparents

FAMILY history of blood clots? Yes ☐ No ☐

Females Only

Are you pregnant or planning on becoming pregnant soon? Yes ☐ No ☐

Are you currently breastfeeding? Yes ☐ No ☐

Do you have more leg discomfort on or around your menstrual cycle? Yes ☐ No ☐

Number of children_____ Number of miscarriages_____

Social History

Occupation: ________________________

Do your daily activities require prolonged periods of standing/sitting? Yes ☐ No ☐

If yes, what activity requires prolonged periods of standing/sitting?

____

Do you now or have your ever used tobacco? Yes☐No ☐ Packs per week_____

- Quit date, if applicable______

Average number of alcoholic beverages per week:

None ☐ 1-5 ☐ 6-10 ☐ 10+ ☐