ALBERT VEIN INSTITUTE
Colorado's Vein Specialist

# Patient Registration
Please fill out completely

Today's Date _____

## PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

Gender _____ DOB ____/____/____ Age _____ SS# _____

Married Single Divorced Widowed (Circle One) Driver's License # _____

Address _____
City State Zip

Home Phone _____ Mobile _____ E-mail _____

Employer _____ Employer Phone _____

Primary Physician _____ Address _____ Phone _____

Referring Physician _____ Address _____ Phone _____

How did you hear about The Albert Vein Institute?
Referred to by my Doctor From a family member/friend Web Other _____

Is this a work related injury or illness? Y / N Is this an injury or illness related to an auto accident? Y / N

## INSURANCE

**FINANCIAL GUARANTOR** (POLICY HOLDER OR PERSON OTHER THAN PATIENT GUARANTEEING PAYMENT)

Last Name _____ First Name _____ MI _____

Gender _____ DOB ____/____/____ Age _____ SS# _____

Relationship to Patient _____ Driver's License # _____

Address _____
City State Zip

Home Phone _____ Mobile _____ E-mail _____

Employer _____ Employer Phone _____

**PRIMARY INSURANCE**

Insurance _____ Member/Policy # _____ Group # _____

Policy Holder's Name _____ Employer _____ Phone _____

**SECONDARY INSURANCE**

Insurance _____ Member/Policy # _____ Group # _____

Policy Holder's Name _____ Employer _____ Phone _____

**EMERGENCY CONTACT** (CLOSE FRIEND OR RELATIVE THAT WE CAN CONTACT IN AN EMERGENCY)

Name _____ Phone _____ Relationship _____

Self-pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for full amount due until the account is satisfied. I understand that I am responsible for copays, co-insurance, and any non-covered services and claims denied by insurance.

I request that payment of authorized insurance and Medicare benefits be made payable to Albert Vein Institute on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay any and all costs of collection including attorney fees, collection fees and court costs. I understand and agree to pay a returned check charge of $25.00 for each check that is returned for any reason. I understand that any unpaid balance sent to a collection agency will be assessed interest at the rate of 18.00% (1.5% monthly). I hereby authorize Albert Vein Institute and its employees, agents, and assignees to contact me via email, text messaging, and to my cellular devices using automated telephone dialing systems.

I authorize the holder of medical information about me to release any and all information to Centers for Medicare or Tricare Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Albert Vein Institute to release information concerning any diagnosis and treatment to my primary care or referring physician after each visit.

I have been made aware of the privacy policies of Albert Vein Institute and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

SIGNATURE OF PATIENTS, INSURED OR GUARANTOR _____

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# Patient Confidential Health History

**Patient Information**
**Page 1**

## MEDICAL HISTORY

Name _____ Today's Date_____

DOB ____/____/____ Age_____

Primary Physician _____ Referring Physician _____

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children (ages): _____

☐ Smoke_____ packs per day for _____ years ☐ Alcohol _____ use for_____ years

What is the reason for this visit? (Check all that apply)

☐ Varicose Veins ☐ Spider Veins ☐ Aching and Pain ☐ Itching and Burning ☐ Tiredness and Fatigue

☐ Restless Legs ☐ Swelling ☐ Leg Cramps ☐ Heaviness ☐ Skin Changes/Skin Ulcers

Other: _____

How long have you had these symptoms?: _____

## VENOUS HISTORY

Do you have a FAMILY history of spider veins or varicose veins? ☐ Yes ☐ No

If so, please check and describe:

☐ Mother_____ ☐ Father_____ ☐ Grandparents _____

Do you have a FAMILY history of deep venous thrombosis, stroke or clotting disorders? Describe which:

☐ Mother_____ ☐ Father_____ ☐ Grandparents _____

## SYMPTOMS

Please check if you have:

☐ Red spider veins ☐ Bulging veins ☐ Purple veins ☐ Flat bluish-green veins ☐ Abdominal veins

☐ Skin discoloration below your knee ☐ Leg ulcer ☐ Purple vein network ☐ Diagnosis of vein disease

Other: _____

Please describe. Do your legs or ankles:

Ache/hurt? _____ Swell? _____

Cramp? _____ Itch? _____

Become tired/Heavy? _____ Other? _____

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

By whom? _____ When? _____

What method? _____

☐ Cosmetic Injections ☐ Laser for Spider Veins ☐ Ambulatory Phlebectomy ☐ Ultrasound-Guided Injections

☐ Radiofrequency closure ☐ Laser Catheter Ablation ☐ Stripping ☐ Ligation

Other: _____

What have your results been?_____

Are you being treated for any current medical conditions? ☐ Yes ☐ No If so, what are these conditions?

_____

**Reviewed By**_____

**Date**_____

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# Patient Confidential Health History

## Patient Information

Do YOU have a history of:

- ☐ Kidney/Bladder Disease
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Diabetes: Insulin Dependent
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ TIA
- ☐ Peripheral Vascular Disease
- ☐ Coronary Heart Disease
- ☐ Heart Valve Problems
- ☐ Anemia
- ☐ Bleeding or Blood Disorder
- ☐ DVT/Blood Clot
- ☐ Pulmonary Embolism
- ☐ Easy Bruising
- ☐ High Blood Pressure
- ☐ Carotid Disease
- ☐ Atherosclerosis
- ☐ Trauma to your legs
- ☐ Hemorrhoids
- ☐ Rupture of a vein
- ☐ Blood Transfusion (Date) _____
- ☐ Cancer of _____
- ☐ Other _____

Past Surgical History. Please list any procedures you have had and the year.

_____ _____

_____ _____

_____ _____

_____ _____

Bleeding History. Please check all that apply.

- ☐ Excessive bleeding
- ☐ Easy Bruising
- ☐ Coumadin Use
- ☐ Aspirin Use
- ☐ Other _____

Please list all medicines that you take (Prescription, Non-Prescription, Vitamins and Herbal):

| Medication | Dose | # Per Day/Frequency | Reason for Taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are you allergic to any medications?

| Medication | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

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# Patient Confidential Health History
Patient Information

**Review of Systems.** Please check all that apply

**Constitution:**
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Fever

**Skin:**
- ☐ Change in size / color of moles
- ☐ Rash
- ☐ Bruising

**Eyes:**
- ☐ Decreased vision
- ☐ Double vision
- ☐ Blurred vision
- ☐ Glasses

**Ear, Nose, Mouth, and Throat:**
- ☐ Pain
- ☐ Deafness
- ☐ Discharge
- ☐ Ringing in ears
- ☐ Sinus drainage
- ☐ Nose bleed
- ☐ Hoarseness

**Cardiac:**
- ☐ Palpitations
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Fatigue
- ☐ Swelling in feet/legs

**Respiratory:**
- ☐ Cough
- ☐ Production of sputum
- ☐ Coughing of blood
- ☐ Pain

**Gastro:**
- ☐ Painful swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomit blood
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Tarry stools
- ☐ Yellow jaundice
- ☐ Bloody stools
- ☐ Change in BMs

**Genito:**
- ☐ Kidney/Bladder disease
- ☐ Decreased urine stream
- ☐ Unable to urinate
- ☐ Painful urination
- ☐ Blood in urine

**Musc/Skel:**
- ☐ Weakness trauma
- ☐ Limited motion
- ☐ Bone/joint deformity

**Neuro:**
- ☐ Paralysis
- ☐ Weakness
- ☐ Seizure
- ☐ Fainting
- ☐ Headache
- ☐ Migraine
- ☐ Migraine with aura
- ☐ Numbness/ tingling in extremities
- ☐ Incoordination
- ☐ Head trauma

**Psych:**
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations

**Endocrine:**
- ☐ Change of appetite
- ☐ Excessive thirst/urination
- ☐ Goiter

**Hemato:**
- ☐ Swollen lymph nodes
- ☐ Bleeding disorders

**Immuno:**
- ☐ Immune disorders
- ☐ Immunosuppressant

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**FEMALES ONLY**

**Breast:**
- ☐ Lump
- ☐ Pain
- ☐ Nipple discharge
- ☐ Infection
- ☐ Trauma

Date of Last Mammogram_____

Date of Last pelvic exam_____

**Gyn:**
- ☐ Irregular periods
- ☐ Birth control
- ☐ Hormone therapy
- ☐ Menopause

Date of Last period _____

History of miscarriages; if so, how many_____

Signature _____ Date_____