Vein Treatment Center of Cheyenne

Patient Registration Form

Please Print

Date of Appointment: _____

Home Phone: (_____) _____

Cell Phone: (_____) _____

I do herby give permission to this office, its successors and assigns to call any cell phones owned or utilized by me. Yes No

Last Name: _____ First: _____ Middle: _____

Preferred first name: _____ Responsible Party (if a minor): _____

Street address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Sex: ◯ M ◯ F Age: _____ Birthdate: _____ Patient social security: _____

Race or Ethnicity: ◯ Caucasian ◯ Hispanic or Latino ◯ Asian ◯ African American ◯ American Indian ◯ Other ◯ Decline

◯ Minor ◯ Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced ◯ Partnered for _____ years

Purpose of visit: _____

Employer: _____ Employer phone number: (____) _____

Who is responsible for this account? _____ Relationship: _____

What is your **preferred pharmacy**? _____

Has any other member of your family been treated in our office: ◯ Yes ◯ No

If yes: _____

Name *Age* *Relationship*

INSURANCE COVERAGE – PRIMARY:

Insurance Co Name: _____ Policy # _____

Name of Policy Holder (Insured) _____ Policy Holder's DOB ____/____/____

Policy Holder's SSN: _____ Relationship to insured: ◯ Self ◯ Spouse ◯ Child

INSURANCE COVERAGE – SECONDARY:

Insurance Co Name: _____ Policy # _____

Name of Policy Holder (Insured) _____ Policy Holder's DOB ____/____/____

Policy Holder's SSN: _____ Relationship to insured: ◯ Self ◯ Spouse ◯ Child

In case of emergency contact: _____ *Phone (____)* _____ *Relationship:* _____

_____ *Phone (____)* _____ *Relationship:* _____

I certify that I, and/ or my dependent(s) have insurance coverage with the above-named company(ies) and assign directly to the Vein Treatment Center all my insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my signature on all insurance submissions. The above-named office may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Date ____/____/____

Signature of Patient or Legal Guardian

Vein Treatment Center of Cheyenne

Authorization to Release Medical Records/Information

I hereby authorize the Vein Treatment Center to speak to the individual(s) named below regarding my care, my test results and my bill:

Name	Relationship
Name	Relationship

Privacy Practices Acknowledgement

I acknowledge this notice of Privacy Practices which is displayed at the Vein Treatment Center of Cheyenne and I have had the opportunity to review it. I can obtain a copy of the Privacy Practices by requesting one from the Vein Treatment Center of Cheyenne.

Patient Financial Responsibility Statement

In order to establish optimal relations with our patients and avoid misunderstanding regarding our patient policies, our staff is trained to inform you of the financial policies of this office.

- It is the patient or guardian responsibility to be aware of your insurance coverage, policies and any exclusions or limitations as well as any authorization requirements. Please contact your insurance to obtain your benefits prior to your surgery.
- We will notify your insurance of the scheduled procedure and bill your insurance for you; however, it is your responsibility to provide us with your most current updated insurance information. You will be responsible for the entire amount of charges if your insurance is not in effect at the time of service.
- Co-payments and co-insurance payments and deductible amounts are the patient or guardian responsibility. These amounts are due within 90 days from the receipt of billing unless other arrangements are made with our billing service.
- Every attempt is made to authorize your surgery with your insurance carrier prior to the procedure. You will be responsible for any services that the Vein Treatment Center physicians believe are medically necessary based on the current standard of quality medical care and are later denied by your insurance.
- Your surgery may require an assistant surgeon and an anesthesiologist is required for all surgeries. The charges for these services are separate from the Vein Treatment Center and the Surgery Center. You will be responsible for these additional charges for your surgery.
- Self-pay procedures must be arranged prior to the actual surgery. Our office can assist you with arrangements; however, agreed upon amount must be paid in full prior to the surgery.
- In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney fees and such costs as the court deems proper.
- You will be responsible for payment of the following additional charges:
  $25.00 will be charged for checks returned for insufficient funds.

I have read the above statements and understand that regardless of insurance coverage, I am responsible for payment of this account. I agree to the terms of the Financial Responsibility as outlined above.

Signature of patient or guardian _____ Date: _____

Vein Treatment Center of Cheyenne

Patient Health History

Patient Name: _____ Date: _____

Who is your Primary Care Physician? _____ Who referred you to our Clinic? _____

Date of last physical exam? _____ Current height _____ Weight _____

Reason for today's visit? _____

Allergies to any medications or substances? _____

_____

List all current medications including any over-the-counter vitamins, herbal or dietary supplements:

_____

_____

_____

Do you have a history of any of the following?

Heart condition	Yes	No	Type of condition: _____
High blood pressure	Yes	No	
Chronic lung condition	Yes	No	Type of condition: _____
Use of oxygen	Yes	No	_____ Liters CPAP or BiPAP? Yes No Settings _____
Leg swelling	Yes	No	
Leg Ulcers	Yes	No	If yes, location, treatment and outcome _____
			_____
Anesthesia complications	Yes	No	
Bleeding abnormalities	Yes	No	Type of abnormality _____
Blood transfusion	Yes	No	If yes, date of transfusion: _____
Blood clot	Yes	No	Date _____ Location of clot _____
Treatment _____			

Do you wear support or compression stockings? Yes No If yes, how long have you worn stockings?

_____

Have you noticed any improvement in your symptoms with the use of support/compression stockings?

Yes No Please explain: _____

Do you elevate your legs during the day or evening? Yes No How often? _____

Do you exercise? Yes No What type of activity and how often? _____

_____

Do your varicose veins restrict your normal daily activities? Yes No How? _____

_____

Patient Health History
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Do your daily activities require periods of prolonged standing? Yes No

If yes, how often during the day do you need to sit or take a break due to leg symptoms?

Never Once per day 2-3 times per day 4 or more times

Do you have pain related to your varicose vein symptoms? Yes No If yes, what medication do you take for the leg pain and how often? _____

Have you had previous vein procedures? Yes No Please specify type of procedure, location and date:

_____

_____

Outcome of procedure(s)? _____

Please list any other previous surgical procedures and the date: _____

_____

_____

Do you use any of the following?			How much and how often?
Caffeine	Yes	No	_____
Tobacco	Yes	No	_____
			Started _____ Quit _____
Alcohol	Yes	No	_____
Street Drugs	Yes	No	_____

Are you currently pregnant? If yes estimated date of delivery _____

Any other significant information needed to assist in your care and medical decisions not otherwise listed:

_____

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY DOCTOR OF ANY CHANGES TO MY HEALTH.

Signature of patient or guardian _____ Date: _____

_____

FOR STAFF USE ONLY

BP _____ Pulse _____ Respirations _____ Temp _____

Vein Treatment Center
Review of Systems

Patient Name: _____

Please mark the conditions that apply:

General		
___ *Chronic fatigue*	___ *Bruise easily*	___ *Fever*
___ *Thyroid disease*	___ *Anemia*	___ *Less interest in doing things*
___ *Weight loss (amount ____)*	___ *Cancer (type)_____*	
___ *Weight gain (amount ____)*	___ *Diabetes*	

Eyes, Ears, Nose & Throat		
___ *Ringing in ears*	___ *Sinus trouble*	___ *Ear infections*
___ *Poor vision*	___ *Wear eyeglasses*	___ *Glaucoma*
___ *Dizzy spells*	___ *Eye infections*	___ *Cataracts*

Lungs		
___ *Pneumonia*	___ *Bronchitis*	___ *Shortness of breath*
___ *Asthma*	___ *Cough*	___ *Emphysema/COPD*

Heart		
___ *Chest pain*	___ *Palpitations*	___ *Irregular heartbeat*
___ *High blood pressure*	___ *Ankle swelling*	___ *Blood clots*

Skin		
___ *Rashes*	___ *Allergic reaction/hives*	___ *Growths*

Urinary		
___ *Urinary infections*	___ *Painful urination*	___ *Blood in urine*
___ *Kidney stones*	___ *Frequency*	___ *Change in urine force or flow*

Bones and Joint		
___ *Arthritis*	___ *Weak bones*	___ *Back pain*
___ *Swollen joints*	___ *Difficulty with ambulation*	

Neurologic/Psychiatric		
___ *Stroke*	___ *Depression*	___ *Seizures*
___ *Tremors/hands shaking*	___ *Nervousness*	___ *Panic attacks*
___ *Numbness or tingling*	___ *Problems sleeping*	___ *Migraines*
___ *Headaches (frequent)*	___ *Memory Loss*	___ *Anxiety*

Gastrointestional		
___ *Diarrhea*	___ *Constipation*	___ *Liver disease*
___ *Heartburn*	___ *Stomach pain*	___ *Gas*
___ *Black stools*	___ *Poor appetite*	___ *Trouble swallowing*
___ *Nausea*	___ *Vomiting*	___ *Trouble with spicy/fatty foods*
___ *Blood in stool*	___ *Bloating*	___ *Abdominal pain after eating*

Additional information you feel is important: _____

_____

_____