Austin Vein & Vascular Clinic

Austin Vein and Vascular Clinic
Dr. Neal T. Foley, MD
Board Certified, American Board of Thoracic Surgery
3944 Ranch Road 620 South
Building 8, Suite 207
Austin, TX 78738
(512) 732 - 7370

Patient Information

Last Name _____ First Name _____

Address _____ Apt #_____ City _____ State _____ Zip Code _____

Date of Birth _____ Age ____ Sex M F Social Security # _____

Preferred Phone _____ (Home, Work, Cell)

E-mail Address _____

Emergency Contact _____ Phone # _____

Relationship _____

Primary Care Physician _____ Phone # _____

Patient Employer _____

How did you hear about us? _____ Referred by _____

INSURED PARTY (*if other than self*)

Last Name _____ First Name _____

Social Security # _____ Date of Birth _____

Insurance Company _____ Phone # _____

Policy # _____ Group # _____

HIPAA/PRIVACY NOTIFICATION: My signature on this form indicates my acknowledgement that I have been provided with the opportunity to read and have access to a copy of Austin Vein & Vascular Clinic's Privacy Notice, which explains how my health information and medical care may be used or disclosed by Austin Vein & Vascular Clinic and will NOT be discussed with anyone other than my doctors and members of my treatment team *(which will include the below authorized members)* without my permission. **Initials** _____

➔ Please provide name(s) of family members that you authorize release to: _____

MEDICAL RELEASE/ASSIGNMENT OF BENEFITS: I hereby authorize payment of all health insurance benefits to Austin Vein & Vascular and allow assignee to release all information necessary to secure payment, I agree that a photocopy of this authorization shall be considered as effective and valid as the original. I understand that I am legally responsible for all charges incurred whether or not they are paid by my health insurance and that any unpaid balance shall be due in-full immediately if insurance proceeds are paid directly to the patient. I understand that if my account should be forwarded to a collection agency, an 18% charge will be added to my account balance. Additionally, I hereby authorize the release of my medical records, inclusive of all test results and pertinent information acquired during my treatment, to/from other physicians/insurance companies as deemed necessary. **Initials** _____

PHOTOGRAPHIC//VIDEO IMAGE CONSENT: I authorize the taking and use of photographic/video images that will show ONLY the treated areas. Consent for this is given with the understanding that my case will not be identified nor will my name/face be used or revealed at any time. **Initials** _____

HIV TESTING AFTER ACCIDENTAL EXPOSURE: I understand that in the event a healthcare worker is exposed to my blood or body fluids during my exam/procedure, my blood may be tested for HIV antibody and other communicable diseases at no cost to me. **Initials** _____

Signature _____ Date _____

Austin Vein & Vascular Clinic

Austin Vein and Vascular Clinic
Dr. Neal T. Foley, MD
Board Certified, American Board of Thoracic Surgery
3944 Ranch Road 620 South
Building 8, Suite 207
Austin, TX 78738
(512) 732 - 7370

Patient Health History Form

Name:_____ Age:_____ Date:_____

Please briefly describe your chief complaint: _____

_____

Who is your Primary Care Physician? _____

How did you hear about us? _____

PAST MEDICAL HISTORY

Have you ever had vein surgery, vein injections, laser treatment, or other types of vein treatment?

Yes No If yes, what type and when?_____

Have you had any tests done or evaluations of your veins?

Yes No If yes, who, what, and when?_____

Have you ever had a blood clot?

Yes No If yes, what leg and when?_____

- If yes, were you treated with a blood thinner (Heparin, Coumadin)? Yes No

Have you ever had phlebitis (inflammation of a vein)?

Yes No If yes, what leg and when?_____

CURRENT HISTORY

Do you currently have any of the following:

Heart Disease	Yes	No	High blood pressure	Yes	No
Lung Disease	Yes	No	Arthritis	Yes	No

Allergies *(medicines, latex, tape, shellfish, etc.)* Yes No

If yes, please specify: _____

Please list any medications you take including prescription and over-the-counter._____

_____

Austin Vein & Vascular Clinic

Austin Vein and Vascular Clinic
Dr. Neal T. Foley, MD
Board Certified, American Board of Thoracic Surgery
3944 Ranch Road 620 South
Building 8, Suite 207
Austin, TX 78738
(512) 732 - 7370

Do you experience any of the following with your legs:

Aching/pain	Yes	No	Tiredness/fatigue	Yes	No
Heaviness	Yes	No	Itching/burning	Yes	No
Swollen ankles	Yes	No	Cramping/throbbing	Yes	No

Do you have any of the following: Varicose veins Spider veins

For how long? _____

Have your veins gotten worse in recent months? Yes No

Do you have discomfort in your legs? Yes No

How long have you had leg discomfort? _____

If you have leg discomfort, what methods do you use to relieve it (*circle*):

Compression stockings/support hose: Yes No *Do they provide relief?* Yes No

➔ If yes, how long have you worn them? _____

Leg Elevation	Walking	Cold Packs	Tylenol	Pain meds
Warm Soaks	Ibuprofen	Aspirin	Exercise	