East Vein
& LYMPHATIC CENTERS

PATIENT DEMOGRAPHICS

Contact Information

Patient Name: _____ Today's Date:_____

Race:_____Ethnicity:Hispanic or Latino ◯ Other ◯

Date of Birth: _____ Age: _____ Sex: Male ◯ Female ◯ N/A ◯

Address:_____ City:_____ State: _____Zip: _____

Home Phone _____ Work Phone _____ Cell Phone:_____

Email: _____Occupation:_____ Religion:_____

Emergency Contact Information

Name:_____Phone: _____ Relationship to you: _____

Insurance Information

How will you pay for medical services? Insurance ☐ Self pay ☐ Other _____

Primary Insurance

Insurance Name: _____Group #: _____ ID/Member #: _____

Cardholder Name and Date of Birth (if different):_____

Secondary Insurance

Insurance Name: _____Group #: _____ ID/Member #: _____

Cardholder Name and Date of Birth (if different):_____

I hereby authorize my insurance benefits to be paid directly to the East Vein and Lymphatic Centers. I understand that I am responsible for all charges and responsible to pay for non-covered services*. I also authorize the release of pertinent medical information necessary to process my insurance request.

Signature: _____ Date: _____

Patient Name Printed: _____

*Certain services may not be covered by managed care plans and insurance companies: services deemed "experimental" and/or "investigational"; procedures deemed cosmetic or non-medically necessary, intra- and post-procedure ultrasounds, tests and compression stockings. You need to discuss with your insurer or plan provider whether treatment provided. in this office is covered and therefore paid for by your specific plan. You are responsible for payment for services provided to you that are not covered or paid for by your health plan.

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HEALTH HISTORY

PatientName:_____**DOB**____/____/____**CELL.**:_____-_____

Any family member with varicose veins?_____

Any major traumas in the past?_____

Any blood clots in the past?_____

Height:_____**Weight**_____

LEG SYMPTOMS

	RIGHT	LEFT
Spider Veins	☐	☐
Varicose Veins	☐	☐
Leg swelling	☐	☐
Leg redness	☐	☐
Leg achiness/Throbbing	☐	☐
Night cramps	☐	☐
Restless legs	☐	☐
Leg heaviness	☐	☐
Restless legs	☐	☐
Leg itching	☐	☐
Leg ulceration	☐	☐
Heat or burning Sensation	☐	☐
Other_____	☐	☐

HEALTH CONDITIONS

Heart problems	☐	PFO (Heart Defect)	☐
Arterial blockages	☐	Easy Bruising	☐
HIV	☐	Leg numbness	☐
Strokes	☐	Leg weakness	☐
Heart attacks	☐	Leg pain walking	☐
High blood pressure	☐	Frequent infections	☐
Diabetes	☐	Shortness of breath	☐
Cancer	☐	Memory loss	☐
Leg trauma/surgery	☐	Depression	☐
Blood clots	☐	Mental health	☐
Migraines	☐	Poor digestion	☐
		Kidney problems	☐

Major surgeries/Hospitalizations_____

_____

Prior vein treatments:_____

Describe any other significant medical condition(s)_____

_____ _____

Since waking up today, how often have you had the following problem in your legs? VVSymQ®

Heaviness	R	L	Achiness	R	L	Swelling	R	L	Throbbing	R	L	Itching	R	L
None of the time	☐	☐	None of the time	☐	☐	None of the time	☐	☐	None of the time	☐	☐	None of the time	☐	☐
A little of the time	☐	☐	A little of the time	☐	☐	A little of the time	☐	☐	A little of the time	☐	☐	A little of the time	☐	☐
Some of the time	☐	☐	Some of the time	☐	☐	Some of the time	☐	☐	Some of the time	☐	☐	Some of the time	☐	☐
A good bit of the time	☐	☐	A good bit of the time	☐	☐	A good bit of the time	☐	☐	A good bit of the time	☐	☐	A good bit of the time	☐	☐
Most of the time	☐	☐	Most of the time	☐	☐	Most of the time	☐	☐	Most of the time	☐	☐	Most of the time	☐	☐
All of the time	☐	☐	All of the time	☐	☐	All of the time	☐	☐	All of the time	☐	☐	All of the time	☐	☐

Women Only:

	YES	NO
Menopause?	☐	☐
Are/were your legs more painful while on your periods?	☐	☐
Are you pregnant or trying to become pregnant?	☐	☐
Are you breastfeeding?	☐	☐
Any worsening bulging veins during pregnancy?	☐	☐
Pain during/after intercourse?	☐	☐
Number of past pregnancies: ____	☐	☐
Deliveries: ____ Children's ages:_____	☐	☐

Wearing compression stockings?

No ☐ Yes, but not recently ☐

Yes,currently ☐

For how long?_____

How many hours a day?

What compression strength?

8-15 ☐ 15-20 ☐ 20-30 ☐ 30-40 ☐

Are you a cigarette smoker? No, never ☐ No, I quit ☐ Yes, current ☐

Alcoholic beverage a week:_____

Patient Signature_____ Date____/____/_____

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HIPAA NOTICE OF PRIVACY PRACTICES

EAST VEIN AND LYMPHATIC CENTERS provides this form in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this form, I understand that my health information may be used and/or disclosed by East Vein and Lymphatic Centers to carry out treatment, payment, or other healthcare operations, and that for a more complete description of such uses and disclosures I should refer to East Vein and Lymphatic Centerers' Notice of Privacy Practices (the "Notice"). I understand that I may request a copy of this Notice to review prior to signing this form if such Notice has not been provided to me.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or other healthcare operations, in accordance with the Notice. I also understand that I can also revoke this consent at any time, but that I can only do so in writing. Revoking consent will not apply to information already disclosed.

(Print Name)

(Patient Signature)*

(Date)

*Not Mandatory

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ALLERGIES AND MEDICATIONS

Patient Name:____________________________ **DOB** ____/____/____________

Pharmacy Name: ________________________________
Address:____
ZIP:_________**Phone Number:**_____________________

Allergies and Your Allergic Response: ☐ ***No Known Allergies***

MEDICATION/FOOD CAUSING ALLERGY

___________________________________ ☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:
___________________________________ ☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:
___________________________________ ☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:
___________________________________ ☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:
___________________________________ ☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:
___________________________________ ☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:

Current Medications: *Include prescription drugs, Over-the-Counter drugs, vitamins, minerals, herbals, dietary (nutritional) supplements*

☐ *None*

#	Medication Name	Dose	Frequency	Route
1				☐Oral ☐
2				☐Oral ☐
3				☐Oral ☐
4				☐Oral ☐
5				☐Oral ☐
6				☐Oral ☐
7				☐Oral ☐

Patient Signature______________________________________ Date____/____/__________

East Vein
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Authorization for Communication of Protected Health Information

Patient Name: _____ **DOB:** / /

We may need to communicate and transmit medical information to a medical provider involved in your care. A member of East Vein and Lymphatic Centers Inc. (DBA East Vein Centers) may need to communicate with you directly or indirectly through a third party business associate. Information about appointments, treatments, instructions, lab results, payments, or other items related to care may be requested by East Vein and Lymphatic Centers. The information may not always be able to be communicated directly to each patient. This authorization authorizes East Vein and Lymphatic Centers employees, or business associates acting on their behalf, to contact me for the purposes described in this document using all the contact information I have provided, including the information on my Patient Information form.Text messaging is not a secure method of electronic communication, and it is possible for someone other than the intended recipient to read texts. Please feel free to contact me via my cell phone if I have provided it as a source of communication. I still consent to receive text messages from East Vein and Lymphatic Centers or its representatives.As a result of providing their names and contact information below, in addition to the informal authorization I previously provided, I authorize East Vein and Lymphatic Centers, Inc to share information about my care or treatments (including Protected Health Information) with the following individuals:

A) Primary Care Physician _____ **Tel:** _____

B) Other Physician/Provider/Person _____ **Tel:** _____

C) Other Physician/Provider/Person _____ **Tel:** _____

Upon signing this document, I release, discharge, and agree to hold harmless East Vein and Lymphatic Centers and any and all third parties acting on its behalf for the purposes described herein from any and all liability resulting from the release of information as authorized above. It is my understanding that I may revoke this consent at any time in writing. The authorization is not subject to expiration unless otherwise revoked in writing.

Signature of Patient or Parent/Guardian _____ **Date** _____

Relationship to Patient (if Minor or Guardian) _____

Click HERE to email this form to:

psr@eastveins.com