Austin Vein & Vascular Clinic

Austin Vein & Vascular Clinic
Dr. Neal T. Foley, M.D.
Board Certified, American Board of Thoracic Surgery
Westlake Hills Medical Center
5656 Bee Caves Road, Suite H-201
Austin, TX 78746
(512) 732-7370

Patient Information

Last Name _____ First Name _____

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

Date of Birth _____ Age ____ Sex M F Other 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 _____

Print Form

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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?_____

FAMILY HISTORY

Does anyone in your family have varicose veins, spider veins, or leg ulcers? ☐ Yes ☐ No

Who? _____

Name:_____ Age:_____ Date:_____

PREGNANCY HISTORY *(if applicable)*

Are you presently pregnant? ☐ Yes ☐ No How many times have you been pregnant?_____

Do you plan on having any more children? ☐ Yes ☐ No

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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._____

_____

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 (circle): ☐ 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 :

Compression stockings/support hose: ☐ Yes ☐ No If yes, 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	

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