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
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 ____________________

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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? ________________________________ Age:______ Date:__________

Name:________________________________

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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 (*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	

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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