VEININNOVATIONS®
A Division of Park Surgical

New Patient Registration Form **Today's Date: / /**

Patient Name: (Last, First, Middle)	**Age**	**Date of Birth (Month/Day/Year)**

Social Security #	**Gender** Male Female	**Marital Status (Please circle one)** Single Married Divorced Widowed

Preferred Language (Please circle one) English Spanish Other: _____	**Race (Please circle one)** American-Indian Asian Black Caucasian Other Declined	**Ethnicity (Please circle one)** Hispanic Non-Hispanic Declined

Street Address

City, State, Zip

Home Phone #	**Work Phone #**	**Cell Phone #**

Patient Email Address:

Employer Information

Employer Name	**Occupation**	**Phone #**

Employer Street Address

City, State, Zip

Key Medical And Lifestyle Information

Major Complaint (Describe pain or concern)

Family History of Varicose Veins?

Emergency Contact (Residing at Different Address)

Name (First Last)	**Phone #**	**Relationship**

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New Patient Medical History

Patient Name			
Office Visit Date	**Date of Birth (Month/Day/Year)**	**Gender** Male Female	**Age**
Reason for Visit:		**Height:**	**Weight:**

Check ALL Applicable Symptoms	**RIGHT Leg**	**LEFT Leg**
Varicose Veins Present		
Spider Veins Present		
Pain in Thigh and/or Calf		
Swelling in Leg and/or Foot		
Fatigue and/or Heaviness in Leg		
Burning and/or Itching		
Night Cramping/Restless Leg		
Severe Discoloration/Ulcer Present		
Bleeding from Varicose Vein		

Do any of your symptoms INTERFERE with (circle Y or N): **Do any of your symptoms IMPROVE with (circle Y or N):**

Occupation	**YES**	**NO**	**Medical Stockings**	**YES**	**NO**
Daily Activities	**YES**	**NO**	**Exercise/Walking**	**YES**	**NO**
Sleep Habits	**YES**	**NO**	**Medication**	**YES**	**NO**
Other: _____	**YES**	**NO**	**Leg Elevation**	**YES**	**NO**

Have you had a previous ultrasound of your legs? YES / NO

Date: _____ Location: _____

Have you had any previous treatment to your leg veins? YES / NO

Date: _____ Location: _____

List of treatment type(s): _____

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Have you worn Medical – Grade Compression Stockings? YES / NO
If so, circle type of stockings: Prescription Grade / Self Purchase

Estimated date and duration worn: _____

CHECK ALL APPLICABLE MEDICAL CONDITIONS			
Deep Vein Thrombosis (DVT)		Diabetes Mellitus (Type 1 / Type 2)	
Superficial Thrombophlebitis		Kidney Disease	
Pulmonary Embolism		Arthritis	
Hypercholesterolemia		Lumbar Spine / Disk Degeneration	
Hypertension		Cancer	
Cardiac Disease		Auto – Immune Disorder	
Peripheral Vascular Disease		HIV / AIDS	
Fainting / Syncope		Hepatitis	
Other:			

Do you have a family history of spider/varicose veins? YES / NO

Do you smoke? YES / NO **Frequency:** _____ **Do you drink alcohol?** YES / NO **Frequency:** _____

Do you use any illicit (street) drug? YES / NO **Type:** _____ **Frequency:** _____

Do you use marijuana? YES / NO **If so, please circle type of use:** Medicinal/Recreational **Frequency:** _____

Do you exercise regularly? YES / NO **Frequency:** _____

Known Allergies: _____

Prior Surgical History: _____

Current Medications: _____

Any past history of significant leg trauma or injury? YES / NO
If so, did you sustain bone fracture and/or require surgery? YES / NO
Circle type of trauma / injury: Fall Motor Vehicle Accident Impact Other

Estimated date of trauma / injury: _____

FEMALES ONLY:					
Currently Pregnant	YES	NO	Post-Pregnancy Varicose / Spider Veins	YES	NO
Currently Breastfeeding	YES	NO	Planning Additional Childbirth	YES	NO
Current Hormone Therapy	YES	NO	Total Number of Full-Term Pregnancies: _____		

CLINICAL STAFF ONLY

VITAL SIGNS	Blood Pressure:	Pulse:
PHOTOS OBTAINED	DATE:	

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Authorization for Release of Information to Primary Care Physician and/or Referring Physician

Did your primary care provider refer you to our practice? ☐ **YES** ☐ **NO**

Did a specialist refer you to our practice? ☐ **YES** ☐ **NO**

If you answered yes to at least one question, please complete the entire form:

Patient Name _____ DOB _____

☐ I authorize **VEIN**INNOVATIONS to release records to my:

Referring Physician: **NAME** _____

PRACTICE NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

If different from above:

☐ I authorize **VEIN**INNOVATIONS to release records to my:

Primary Care Physician: NAME _____

PRACTICE NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

☐ I do ☐ I do not ☐ N/A

Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus).

This authorization will expire one year after it is signed

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule. I have the right to revoke this authorization in writing except to the extent that VeinInnovations has acted in reliance upon this authorization. My written revocation must be submitted to VeinInnovations Privacy Officer at 4255 Johns Creek Parkway, Suite D, Suwanee, GA 30024. Phone: 678.731.9815

By signing this authorization, I authorize to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed above.

Patient Signature: _____ ***Date:*** _____

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