**New Patient Registration Form** **Date: / /**

| Patient Name: (Last, First, Middle) | | | Age | Date of Birth (Month/Day/Year) |
|---|---|---|---|---|
| **Social Security #** | | **Gender**<br>Male Female | **Marital Status (Please circle one)**<br>Single Married Divorced Widowed | |
| **Preferred Language (Please circle one)**<br>English Spanish Other: ___________ | **Race (Please circle one)**<br>American-Indian Asian Black<br>Caucasian Other Declined | | **Ethnicity (Please circle one)**<br>Hispanic Non-Hispanic<br>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** | | |

**Emergency Contact (Residing at Different Address)**

| Name (First Last) | Phone # | Relationship |
|---|---|---|
| | | |

| How did you hear about us? (Please circle one) | | | |
|---|---|---|---|
| Google | **Vein**Innovations Website | Referring Doctor | Word of Mouth |
| Insurance Company | Health Fair (Date:_______) | Social Media | Other |
| **If Other, please specify:** | | | |



Revised 6.2020

**New Patient Medical History**

| **Patient Name** | | | |
|---|---|---|---|
| **Office Visit Date** | **Date of Birth (Month/Day/Year)** | **Gender**<br>Male Female | **Age** |
| **Reason for Visit (Describe pain or concern):** | **Height:** | **Weight:** | |
| **Do you have a family history of spider/varicose veins?** ☐ **YES** ☐ **NO** | | | |

| **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 YES or NO):** **Do any of your symptoms IMPROVE with (circle YES or NO):**

| **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): ________________________________________________________________________________

**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 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, 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: | | |

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**CLINICAL STAFF ONLY**

| VITAL SIGNS Blood Pressure: | Pulse: |
|---|---|
| PHOTOS OBTAINED DATE: | |

## 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 **Vein**Innovations has acted in reliance upon this authorization. My written revocation must be submitted to **Vein**Innovations 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: ________________**

### Authorize for Release of Health Information

In the event **Vein**Innovations needs to contact you regarding your medical records or appointment, please list the telephone number and email at which you may be reached:

Phone: ____________________________________________ Email: ____________________________________________

In the event you are not available do you give permission to **Vein**Innovations to leave a voice message on a voice-messaging device?

☐ **YES**, I give permission for HOME / CELL / WORK (please circle all that apply) ☐ **NO**, I do not give permission

List of person(s) to release information to:

Name: ____________________________ Relationship: ____________________ Contact Number: _________________

Name: ____________________________ Relationship: ____________________ Contact Number: _________________

Name: ____________________________ Relationship: ____________________ Contact Number: _________________