Patient Information Sheet

Varicose Vein Clinic Of Oklahoma

E-mail Address _____Date:_____

Patient Name:_____ Sex: M F

Date Of Birth:_____ Age:_____ SSN: _____

Marital Status: Single Married Divorced Widowed Race:_____

Patient Address: _____ City:_____ St:_____Zip:_____

Home Phone: ( )_____Work Phone_____Cell Phone: _____

Referring Physician: _____ Phone: ( )_____

Employer:_____ Address: _____

Spouse Name: _____ Date of Birth: _____

Cell Phone: ( )_____ SSN: _____

Spouse Employer: _____ Work Address: _____

How did you hear about us? (Circle any that apply)

Friend/ Family Name(s): _____ / Other Patients Name(s): _____ /Newspaper / Dr Name: _____ / Other Explain: _____

Emergency Contact: _____ Phone: ( )_____

Do you Have Insurance? YES NO Please present INS card(s) to receptionist

Name of Primary Insurance:_____ Policy Holder Name:_____

Name of Secondary Insurance:_____ Policy Holder Name:_____

Answer the following questions if under 21

Mother's Name: _____ SSN: _____ DOB:_____

Employer:_____ Phone: ( )_____ Address: _____

Father's Name: _____ SSN: _____ DOB: _____

Authorization for services/ Please read and sign at the bottom of this form.

I hereby authorize payments directly to the Physician, staff, or facility for medical services rendered. I understand I am responsible for any portion of my bill not covered by my insurance company, whether as a co-pay, co-insurance, deductible, or non-covered service. I understand office co-pays are due at the time services are rendered. I also understand all the above and state that the information provided herein is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practice

This acknowledges I have received the Notice of Privacy Practices from my provider

Signature:_____ Date: _____

How long has your Vein Problem Existed?_____

Do your legs bother you? Yes_____ No_____

If yes, Please
describe:_____
_____

Vein Size And Location (Check All That Apply)

Right Leg_____ Large_____ Medium_____Spider Veins_____

Left Leg _____ Large_____ Medium_____Spider Veins_____

Have you ever had your veins treated before? Yes_____ No_____ (Check All That Apply)

Stripping:_____ Date:_____ Injections:_____ Date:_____

Support hose:_____ Yes/No If yes, How long have you used them?_____

Medical History: (Check All That Apply)

High Blood Pressure ____ Heart Disease _____
Diabetes ____ High cholesterol____
Stroke ____ Other _____

Medications: (Please list all medications that you are currently taking)

List Attached:_____

Name: Dose: Frequency

_____/_____/_____

_____ /_____/_____

_____/_____/_____

_____/_____/_____

I am currently not taking any medications: Initial_____

Drug Allergies:

Please Initial if none:_____

History of Blood Clots in your Veins? Circle one Yes / No Deep:_____ Surface Veins:_____

Family history of Varicose Veins: **(Check all that Apply)**

Father _____ Sisters_____

Mother _____ Brothers _____

The Varicose Vein Clinic
Patient History-Information Sheet

Name:_____

Date: _____

D.O.B._____

Age:_____

How long has your vein problem existed? _____

Are the veins symptomatic (ache, burn, pressure, tenderness) Yes/ No

If yes, please describe:_____

Have you ever worn compression hose on your legs? Yes/ No

If yes, Please list years or months: _____

Pain:

Constant _____
Intermittent _____
Worse despite stockings _____
Worse with stockings _____
Cannot wear stockings _____

Relieved By:

Resting Legs _____
Elevating Legs _____
Cold _____
Heat _____
Walking _____
Pain Meds (Name) _____
Stockings _____

Previous History:

Deep Vein Thrombosis _____
Phlebitis _____
Venous Surgery _____ If yes, please explain
_____
Pulmonary Embolus _____
Arterial Surgery _____
Injury To Veins _____

Signs Of Symptoms:

Stinging _____
Pulsating _____
Tenderness _____
Swelling _____
Discoloration _____
Numbness _____
Burning _____
Aching _____
Ulcerations _____

Varicose Vein Clinic
Release Of Medical Information

Patient Name:_____
Social Security Number:_____
Date Of Birth:_____

This will serve as authorization to release all medical records contained in the medical chart that relates to any physical condition or treatment given by any physician employed by **Varicose Vein Clinic** to the above named patient. This will also serve as authorization for release of information to referring physicians and the patients insurance company for insurance claim purposes.
The information authorization for release may include records which may include the presence of a communicable venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS). Oklahoma Statute: 63 OS 1.502.2.
I also authorize you to accept a photo copy of this release and it shall have the same force and effect as if it were the original.
I acknowledge that I understand all of the above information. My signature indicates that I have read this Medical Release and grant the request for Authorization.

Signature_____ **Date:**_____

Medicare Patients Only

I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers of any information needed for this or a payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for medical treatment.

Signature:_____**Date:**_____

The Varicose Vein Clinic Of Oklahoma
&
Oklahoma SkinCare

NO SHOW/CANCELATION POLICY

In an effort to provide the most flexible scheduling, ensure the best experience for all of our patients, as well as the fact that some of our schedules are booked 6-8 weeks in advance, it has become necessary to institute a "No Show/Cancellation" Policy.

Effective April 1st 2008, any canceled or missed appointment without at least a 24 hour notice will result in a $50 cancellation/rescheduling fee, which must be paid prior to rescheduling the appointment.

Our staff will make every effort to give you a courtesy call 24-48 hours prior to your scheduled appointment, but it is your responsibility to keep the appointment or give us at least 24 hours advance notice if you need to reschedule or cancel.
By signing below, you state that you are aware of the charge should you be unable to provide the 24hr notice before canceling or rescheduling your appointment.

Thank you for your consideration

_____

_____

Patient Signature **Date**