

VEIN REGISTRATION

Date: ___/___/___ How were you referred? Internet Physician Patient Other: _____

Name of referring physician: Dr. _____ Name of primary care physician: Dr. _____

GENERAL INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: ___ Date of Birth: ___/___/___ LAST 4 of SS#: _____ Marital Status: _____ Spouse's Name: _____

Occupation: _____ Employer: _____

Employer Address: _____

Telephone Home: (____) _____ - _____ Business: (____) _____ - _____ Cell: (____) _____ - _____

Contact number during work hours: Home Business Cell Contact number after work hours: Home Business Cell

Emergency Contact: Name: _____ Phone: (____) _____ - _____ Relationship: _____

E-MAIL: _____ YES / NO Please register me for email updates (*we do NOT share email addresses with other businesses*)

VARICOSE & SPIDER INFORMATION

Circle: Male / Female Height: _____ Weight: _____

Reason for current visit: _____

Duration of this problem: _____

Where are the sites of your unwanted veins? _____

At what age did your veins first appear? _____ Have the veins continued to progress within the past five years? YES / NO

Have you had a prior injury over the sites of unwanted veins? YES / NO *If YES, provide details* _____

Do you have any symptoms that you associate with your veins? YES / NO *If YES, provide details* _____

Do varicose or spider veins run in your family? YES / NO

If yes, complete the following:

MOTHER YES / NO IF YES: VARICOSE SPIDER BOTH
 FATHER YES / NO IF YES: VARICOSE SPIDER BOTH
 SISTERS YES / NO IF YES: VARICOSE SPIDER BOTH
 BROTHERS YES / NO IF YES: VARICOSE SPIDER BOTH
 AUNTS YES / NO IF YES: VARICOSE SPIDER BOTH

MATERNAL GRANDMOTHER YES / NO IF YES: VARICOSE SPIDER BOTH
 MATERNAL GRANDFATHER YES / NO IF YES: VARICOSE SPIDER BOTH
 PATERNAL GRANDMOTHER YES / NO IF YES: VARICOSE SPIDER BOTH
 PATERNAL GRANDFATHER YES / NO IF YES: VARICOSE SPIDER BOTH
 UNCLES YES / NO IF YES: VARICOSE SPIDER BOTH

Have you ever had treatment for varicose or spider veins? If YES answer the following:

Have you had any surgical treatment? YES / NO *If YES, provide details:* _____

Have you had endovenous ablation? YES / NO *If YES, provide details:* _____

Have you had sclerotherapy treatment? YES / NO *If YES, provide details:* _____

Have you had any other treatments for varicose or spider veins? YES / NO *If YES, provide details:* _____

Have you had any previous consultations or diagnostic testing done because of your veins? YES / NO *If YES, provide details:* _____

COSMETIC INTEREST (optional) - Please check additional interests

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> BOTOX® Cosmetic | <input type="checkbox"/> VANQUISH Fat Removal | <input type="checkbox"/> THERMAGE CPT | <input type="checkbox"/> VEIN TREATMENTS |
| <input type="checkbox"/> BOTOX® for Under Arm Sweat | <input type="checkbox"/> IPL PHOTO-FACIALS | <input type="checkbox"/> TATTOO REMOVAL | <input type="checkbox"/> ENDOVENOUS ABLATION |
| <input type="checkbox"/> JUVEDERM XC | <input type="checkbox"/> SKIN CARE & PRODUCTS | <input type="checkbox"/> SKIN CANCER SCREENING | <input type="checkbox"/> MICRO-NEEDLING |
| <input type="checkbox"/> VOLUMA XC | <input type="checkbox"/> FACIALS | <input type="checkbox"/> PEELS | <input type="checkbox"/> MICRODERMABRASION |

Are you prone to scarring? YES / NO If YES, provide details: _____

Are you prone to brown patches after minor injuries? YES / NO If YES, provide details: _____

Are you prone to bruising? YES / NO If YES, provide details: _____

Current medical problems: _____

Past medical problems: _____

Current medication (prescription and OTC): _____

Allergies to medications: _____

Do you smoke cigarettes? YES / NO If YES, provide details (# of years, packs per day): _____

Have you ever been tested for hepatitis? YES / NO If YES, provide details: _____

Have you ever been tested for HIV? YES / NO If YES, provide details: _____

Are you prone to lightheadedness or fainting? YES / NO If YES, provide details: _____

Is your skin sensitive to cold? YES / NO If YES, provide details: _____

Does your skin become mottled (red, pink, blue) when exposed to cooler temperatures? YES / NO If YES, provide details: _____

Are you prone to swelling in your feet, ankles or legs? YES / NO If YES, provide details: _____

Have you ever had Phlebitis (blood clots)? YES / NO If YES, provide details: _____

Do you have a family history of Phlebitis? YES / NO If YES, provide details: _____

MEDICAL INSURANCE INFORMATION

I authorize the release of any medical information that may be requested by my insurance carrier. _____

Name of insurance carrier: _____

PRIMARY INSURANCE HOLDER INFORMATION

Name of primary insurance holder: _____ Date of birth: _____

Member identification number: _____ Group number: _____

Insurance phone number: _____

Phone number: _____ Primary insurance holder address: _____

THIS SECTION TO BE COMPLETED BY WOMEN

Are you pregnant? YES / NO Is there a possibility that you are pregnant? YES / NO Are you breast-feeding? YES / NO

Have you ever been pregnant? YES / NO

If YES: # pregnancies _____ # full term pregnancies _____ date (year) of each pregnancy _____

If YES, did your veins appear prior to pregnancy? YES / NO

Did your veins get worse during pregnancy? YES / NO

Did your veins improve post-partum? YES / NO

Do you currently use (or have ever used) a contraceptive? YES / NO If YES, indicate name(s) and years taken _____

ALL PATIENTS - PLEASE INITIAL & SIGN

Please add any additional comments: _____

I certify that the above information is true to the best of my knowledge. _____

I certify that a HIPAA Form is being provided. _____

_____ I understand that it is my responsibility to confirm all of my network benefits before services are rendered by

Dr. David Green, and that I am responsible for my co-payment or deductible balance as well as any other fees incurred that are NOT covered by my insurance at the time of my visit.

_____ I further understand that I will be responsible for any charges that are incurred on my behalf including insufficient funds, bank charges, attorney fees and/or collection fees.

_____ **Cancellation Policy:** We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

I UNDERSTAND THAT THERE IS A CHARGE FOR THIS CONSULTATION, depending upon the degree of complexity of my visit.

SIGNATURE: _____ **DATE:** _____