Vein Healthcare Center

35 Foden Road | South Portland, Maine 04106

tel: 207-221-7799 | fax: 207-221-3544 | info@veinhealthcare.com | www.veinhealthcare.com

Demographic Information

Contact Information

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: ☐Male ☐Female

Address: _____

City: _____ State: _____

Zip: _____ Social Security Number: _____

Home Phone _____ Work Phone _____

Cell Phone: _____ Other Phone: _____

Which phone number should we use first? _____

Email: _____

When we confirm your visit, how would you like us to reach you? ☐Phone ☐Postcard ☐E-mail

Emergency Contact Information

Name: _____

Phone: _____

Relationship to you: _____

Insurance Information

How will you pay for medical services? ☐Insurance ☐Self pay ☐ Other _____

Primary Insurance	Secondary Insurance
Insurance Name: _____	_____
Group #: _____	_____
ID/Member #: _____	_____
Insurance Type: _____	_____

Scheduling Preferences

☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐AM ☐PM ☐No preference

Additional Information

How did you hear about the Vein Healthcare Center?

I hereby authorize my insurance benefits to be paid directly to the Vein Healthcare Center. I understand that I am responsible for all charges and responsible to pay for non-covered services. I also authorize the release of pertinent medical information necessary to process my insurance request.

Signature: _____ Date: _____

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Medical Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: ☐Male ☐Female

Primary care provider: _____

Primary care provider address: _____

Primary care provider phone: _____

Vein History

Do your legs bother you? ☐Yes ☐No If yes, please check all that apply:

- ☐ Aching
- ☐ Cramping
- ☐ Throbbing
- ☐ Pain
- ☐ Swelling
- ☐ Itching
- ☐ Heaviness
- ☐ Ulcers
- ☐ Numbness

Other/Comments:

Have you ever worn compression stockings? ☐Yes ☐No If yes, when and for how long?

Have you had past vein treatment or had leg veins examined by a physician? ☐Yes ☐No If yes, please describe:

Do you ever take Aspirin, Tylenol, or Ibuprofen for your leg symptoms? ☐Yes ☐No

Do your legs prevent you from doing any activities (e.g. standing for long periods, swimming, wearing shorts, sleeping)? ☐Yes ☐No If yes, please describe:

Have you had injury to your legs requiring casting? ☐Yes ☐No

Please check any of the medical conditions below that you have experienced:

- ☐ Deep Vein Thrombosis (DVT)
- ☐ Superficial Vein Phlebitis
- ☐ Venous Stasis Ulcer
- ☐ Bleeding from Varicose Veins
- ☐ Vein Treatment
- ☐ Other

Medical History

Do you see a doctor regularly for any medical condition? ☐Yes ☐No If yes, please describe:

Please check any health or disease related issues you might have:

- ☐ AIDS
- ☐ Anemia
- ☐ Bleeding/Clotting Disorder
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis
- ☐ Deep Vein Thrombosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lung Disease
- ☐ Nervous Breakdown
- ☐ Pneumonia
- ☐ Stroke
- ☐ Ulcers
- ☐ Other? _____

Medical Information

Have you had any serious injuries? ☐Yes ☐No If yes, please list the date and type of injury:

Past Surgeries

Please list past surgeries:

Family History

	Major Illness	Age	Deceased?
Mother:	_____	_____	☐Yes ☐No
Father:	_____	_____	☐Yes ☐No
Sibling 1:	_____	_____	☐Yes ☐No
Sibling 2:	_____	_____	☐Yes ☐No
Sibling 3:	_____	_____	☐Yes ☐No

Social History

Current/Past occupation?: _____ Marital status: _____

Do you smoke? ☐Yes ☐No How much? Quit date? _____

Do you drink alcohol? ☐Yes ☐No If yes, how much? _____

Do you exercise? ☐Yes ☐No If yes, please describe: _____

Medication

Please list current medications:

OB History (Women only)

Is there a chance that you are pregnant? ☐Yes ☐No How many times have you been pregnant? _____

How many children have you birthed? _____ Complications?

Allergies

Please list allergies:

Medical Conditions *(circle any that apply)*

General Health: ☐Recurrent infections/fever, ☐fatigue, ☐recent weight gain or loss, ☐night sweats, ☐decreased appetite. Comments:

Emotional: ☐Depression, ☐anxiety attacks, ☐crying spells, ☐alcohol/drug problems, ☐problems falling asleep, ☐nervousness, ☐suicidal thoughts. Comments:

Eyes: ☐Wear glasses or contacts, ☐eye infections, ☐blurred vision. Comments:

Medical Information

Medical Conditions *continued*

Head, Ears, Nose, Mouth, Throat:	Ear infections, headaches, fullness in head, sore throat, nose bleeding. Comments:
Heart:	Chest discomfort, tightness, heart murmur, swollen ankles, shortness of breath, rheumatic fever, high blood pressure. Comments:
Lungs:	Difficulty breathing, cough, wheezing, cough blood or mucus, sleep on more than one pillow. Comments:
Lymphatic/Blood Vessels:	Excessive bleeding, bruise easily, swollen lymph nodes. Comments:
Muscle/Bone/Joints:	Joint pain, stiffness, swelling, muscle pain, muscle cramping or spasms, neck/back pain. Comments:
Nervous System:	Fainting or loss of consciousness, convulsions, seizures, dizziness, memory changes. Comments:
Reproductive:	Burning pain when urinating, frequent urination, sudden impulse to urinate, irregular periods, clots, cramps, prostate problems. Comments:
Skin/Breasts:	Sore, rash/itching, lumps/growths, changes in moles, hair loss, swollen glands, tenderness or pain in breasts, discharge from breasts. Comments:
Stomach and Intestinal:	Special diet, change in appetite, heartburn, nausea/vomiting, problems swallowing, black stools, ulcers, constipation, use antacids. Comments:
Other:	Please describe any other medical conditions you may have:

Additional Medical Information

Please share any details about your health that you feel may be relevant and not previously mentioned?:

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NOTICE OF PATIENT RESPONSIBILITY FOR NON-COVERED SERVICES

The following services, among others, may not be covered by managed care plans and insurance companies: services deemed “experimental” and/or “investigational”; procedures deemed cosmetic. However, you need to discuss with your insurer or plan provider whether treatment provided in this office is covered and therefore paid for by your specific plan. You are responsible for payment for services provided to you that are not covered or paid for by your health plan.

Patient Signature: _____ Date: _____

Patient Name Printed: _____

Vein Healthcare Center

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

You have the right to refuse to sign this consent

Vein Healthcare Center provides this form in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this form, I understand that my health information may be used and/or disclosed by Vein Healthcare Center to carry out treatment, payment, or other healthcare operations, and that for a more complete description of such uses and disclosures I should refer to Vein Healthcare Center's Notice of Privacy Practices (the "Notice") a copy of which has been provided to me. I understand that I may request a copy of this Notice to review prior to signing this form if such Notice has not been provided to me.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or other healthcare operations, in accordance with the Notice. I also understand that I can also revoke this consent at any time, but that I can only do so in writing. Revoking consent will not apply to information already disclosed.

_____

(Print Name)

_____

(Patient Signature)

_____

(Date)

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Appointment Reminder Form

Please check the box with the preferred method of communication you choose to be notified of your upcoming appointments at Vein Healthcare Center.

- ❑ Email and text message
- ❑ Email only
- ❑ Text message only
- ❑ I prefer a telephone call reminder
- ❑ I do not wish to receive appointment reminders

Email Address: _____

Mobile Phone Number: _____

Patient Name Printed: _____

Patient Signature: _____ Date:_____

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Vein Healthcare Center

The Vein Healthcare Center is near the Portland Jetport and the Maine Mall and is easily accessible from I-295, I-95, U.S. Route 1, and other local routes.

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DETAILED DIRECTIONS TO THE VEIN HEALTHCARE CENTER

From Greater Portland, Mid-Coast, and Down East including Freeport, Boothbay, and Belfast

I-295 South to exit 3, Westbrook Street. At the traffic light, turn right on to Westbrook Street. Continue through the next traffic light. At the second light, Western Avenue bears off to the right. Continue on Western Avenue. At the next light turn left on to Foden Road and then immediately right in to our parking lot.

From the South, including Saco, Portsmouth, Boston and Connecticut

I-95 North to exit 46, (Portland Jetport). Turn right at the traffic light on to Skyway Dr. towards the Jet Port. At the light, turn right on to Johnson Rd/Western Ave. Continue through the next traffic light (passing Staples on the left). Our parking lot entrance is immediately after the Coca Cola plant on the right.

From the North, including Augusta, Bangor, Lewiston/Auburn, and Canada

I-95 South to exit 46, (Portland Jetport). Turn right at the traffic light on to Skyway Dr. towards the Jet Port. At the 2nd light, turn right on to Johnson Rd/Western Ave. Continue through the next traffic light (passing Staples on the left). Our parking lot entrance is immediately after the Coca Cola plant on the right.