



PATIENT REGISTRATION

Date: _____

Last Name: _____ First Name: _____ M: _____ Date of Birth: _____

SS #: _____ Male _____ Female Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers:

Home: _____ Business: _____ Mobile: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ Caucasian/White ☐ Refused/Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused/Declined

Email Address: _____

(This is required so that we can give you access to your healthcare information)

If you do not have an email please initial below:

_____ (Initial) I decline access to my medical records. I understand the benefits and do not wish to have access to my health records.

How did you hear about us? _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Social History:

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced Occupation: _____

Do you have any children? _____ Age/Sex of Children: _____

Patient lives with: ☐ Self ☐ Spouse ☐ Other (Parent/Child/Friend)

Employer: _____

Do you drive: ☐ Yes ☐ No Do you have stairs in your home: ☐ No ☐ Yes, How Many? _____

Do you often sleep in a reclining chair? ☐ No ☐ yes, How often? _____

Do you use Tobacco? ☐ No ☐ Yes -For how long? _____ How much, Packs Per Day? _____

If you have quit smoking, when did you quit? _____ How long did you smoke prior to quitting? _____

Do you use Alcohol ☐ Yes ☐ No How much week? _____ Weight: _____ Height: _____

Patient Signature: _____ **Date:** _____

Patient History Form

Date: _____

Last Name: _____ First Name: _____ MI: _____ Birthdate: _____

Referring Physician: _____ Primary Physician: _____

Medical History: (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Kidney Disease (Renal Failure) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Leg Ulcers |
| <input type="checkbox"/> Cancer (Site _____) | <input type="checkbox"/> Liver Disease (Cirrhosis) |
| <input type="checkbox"/> Cerebrovascular Disease | <input type="checkbox"/> Lymphedema/Leg Swelling |
| <input type="checkbox"/> Cervical Spine Disease (neck problems) | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Claudication | <input type="checkbox"/> Pacemaker/AICD |
| <input type="checkbox"/> COPD (Lung Disease) | <input type="checkbox"/> Peripheral Arterial Disease (PAD) |
| <input type="checkbox"/> Heart Disease- | <input type="checkbox"/> Raynaud's Disease Syndrome |
| Coronary Artery Disease- CAD | <input type="checkbox"/> Stroke/TIA |
| Congestive Heart Failure- CHF | <input type="checkbox"/> History of Phlebitis |
| Myocardial Infarction- Heart Attack | <input type="checkbox"/> Gastro-esophageal Reflux Disease (GERD) |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Lumbar Spine Disease (Back Problems) |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Migraines | |

Medications:

Dose:

Start Date:

Surgical History (check all that apply and list date):

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Bypass (CABG) _____ | <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Heart Angioplasty _____ |
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Breast Surgery _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> Gallbladder Surgery _____ | <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Foot Surgery _____ |
| <input type="checkbox"/> Colon Surgery _____ | <input type="checkbox"/> Back Surgery _____ | <input type="checkbox"/> Varicose Vein Surgery _____ |

Have you had any recent Hospitalizations within the last 6 months? ☐ No ☐ Yes, Cause: _____

Allergies and Reactions (Include Latex): _____

	Age, If Living	If Deceased, Age and Cause	Health Problems
Father			
Mother			
Sister/Brother			
Sister/Brother			
Sister/Brother			

Patient Signature: _____ Date: _____

NORTHWEST Vascular and Vein Specialists

Susanne K. Woloson, MD, PhD, RPVI & Elizabeth T. Clark, MD, RVT, FACS
1614 West Central Road, Suite 100, Arlington Heights, IL 60005
900 Technology Way, Suite 230, Libertyville, IL 60048
847-577-5814 Fax- 847-577-5914

Financial/Insurance Acknowledgement

Financial

Complete billing information will be provided at the time of your appointment. Those patients who do not have insurance or are unable to provide adequate billing information are responsible for the total payment of their bills. **Initial** _____

Self Pay

I understand that I am financially responsible for services received and that I am eligible for a payment plan for my balance with my physician. Any payments that lapse over a 3 month period of time will be sent to a collection agency.

Initial _____

No Show/Cancellation Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar (\$50) fee for a office visit and one hundred dollar (\$100) for procedures; this will not be covered by your insurance company. **Initial** _____

Insurance

As a courtesy, our billing department will bill your insurance on your behalf provided that you supply all of the necessary information at the time of service. Any services that are not paid by your insurance will become your financial responsibility. Due to the number of insurance plans that we work with and the different contracts our providers have as their own entities, it is not possible for us to know all the covered benefits your specific plan covers. We ask that our patients familiarize themselves with the different benefit levels available and whether certain services are covered, specifically any services or procedures Please notify our front desk staff if you are aware that certain services are not covered and be prepared to make payments for that service on the day of your appointment. Patients without coverage are eligible to receive a prompt pay discount if payment is received on the day the service is rendered. **Initial** _____

HIPAA – Patient Acknowledgement Form

I, _____, hereby acknowledge receipt of Northwest Vascular and Vein Specialists Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me.

I authorize Northwest Vascular and Vein Specialists to discuss my medical treatment with:

Only Myself: _____

Phone Numbers: _____

And/Or: Name: _____ Relationship: _____ Phone: _____

Messages may be left on my answering machine or voicemail: YES: _____ NO: _____

Messages may be left with one of the people listed above: YES: _____ NO: _____

Patient Signature: _____ **Date:** _____

NORTHWEST Vascular and Vein *Specialists*

Varicose Vein Form

1. When did you first notice varicose veins? _____
2. When did your varicose veins begin to bother you? _____
3. Have you ever had a Venous Reflux Ultrasound done to evaluate your veins? ☐ Yes ☐ No
Where was test done and when? _____
4. Have you ever had any prior treatment of your varicose veins? ☐ Yes ☐ No
If yes, what type of treatment?
Vein stripping surgery? ☐ Yes ☐ No
If yes, when and which leg? _____
Laser therapy or radiofrequency ablation? ☐ Yes ☐ No
If yes, when and which leg? _____
Injection /Sclerotherapy (vein injections)? ☐ Yes ☐ No
If yes, when and which leg? _____
5. Have you ever had a blood clot (DVT)? ☐ Yes ☐ No
If yes, which leg and when? _____
How was this treated? Heparin Coumadin Aspirin No Treatment
6. Have you ever had phlebitis (redness/inflammation)? ☐ Yes ☐ No
If yes, which leg and when? _____
7. Have you ever had a venous ulcer? ☐ Yes ☐ No
If yes, which leg and when? _____
How was this treated? ☐ UNNA boot ☐ Compression stocking/wrap ☐ Antibiotics ☐ No Treatment ☐ Other _____
8. Do you have any bleeding or clotting disorders? ☐ Yes ☐ No
9. Have your veins gotten worse in recent months? ☐ Yes ☐ No
Describe: _____
10. Do you experience any of the following symptoms in your legs?

Aching/pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Both Legs
Heaviness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Both Legs
Tiredness/fatigue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Both Legs
Itching/burning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Both Legs
Swollen ankles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Both Legs
Night cramps?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Both Legs
Restless legs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Both Legs
Throbbing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Both Legs
11. Have you ever had bleeding from your leg veins before? ☐ Yes ☐ No
If yes, explain: _____
12. Do your symptoms interfere with your work or daily activities? ☐ Yes ☐ No
If yes, how? _____
13. Do you take any medication for your vein symptoms (i.e., Advil, Motrin)? ☐ Yes ☐ No
If yes, what medication(s) do you take and how many times/mgs per day? _____
14. Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No
If yes, how long per day do you elevate and does it provide relief? _____
15. Do you exercise? ☐ Yes ☐ No
If yes, what kind of exercise and how often? _____
16. Do you wear prescription compression stockings? ☐ Yes ☐ No
If yes, what type? _____ How long have you worn them? _____
17. Do you wear light support hose (i.e., Sheer Energy)? ☐ Yes ☐ No
18. Do you have any problem walking? ☐ Yes ☐ No
If yes, describe _____
19. What type of work do you do? _____ How long do you stand (hours): _____

Patient Signature: _____ **Date:** _____

