NORTHWEST Vascular and Vein Specialists

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 you 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)

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

Medications: **Dose:** **Start Date:**

_____

_____

_____

_____

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

❒Heart Bypass (CABG) _____
❒Appendectomy _____
❒Gallbladder Surgery_____
❒Colon Surgery_____
❒Hysterectomy_____
❒Breast Surgery_____
❒Cataracts _____
❒Back Surgery_____
❒Heart Angioplasty_____
❒Tonsillectomy_____
❒Foot Surgery_____
❒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:**_____

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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?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Heaviness?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Tiredness/fatigue?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Itching/burning?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Swollen ankles?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Night cramps?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Restless legs?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Throbbing?	□ Yes	□ No	□ Left	□ Right	□ 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:**_____

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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_____**

Patient Signature:_____Date:_____