Dear ____________________________,

We are looking forward to meeting you, and assisting you to obtain good health. Enclosed in this package, you will find several forms, **please complete, and bring them to your appointment:**

Patient registration form

Medical history form (Please Sign & Date)

Authorization to Release Information

Please also bring your insurance card

Your scheduled appointment is on _____/_____/_____ at ________.

To assure that the doctor can make complete examination of your legs, **please bring a pair of shorts** to change into for your consultation. Shorts should not be too tight or too long--running shorts are ideal. Please be aware that we try to run on schedule, if you are more than 10 minutes late, you may be asked to reschedule out of courtesy to our other patients. So if you are unfamiliar with the area, leave extra time in case you get lost on your way to the office. We are located on Southpark Drive, off Highway 54, near the Streets at Southpoint Mall, just off of I-40 at the Fayetteville Road exit. Please see the attached sheet for directions from your location.

The charge for your consultation is $65.00. We expect payment at the time of service. We will be happy to file this visit with your insurance company. If you should have any questions, please do not hesitate to call our office.

Sincerely,

Vein Help of the Triangle

PLEASE NOTE: It is difficult for the physician to give you his full attention with children present. Please make other arrangements for your childcare if at all possible.

***** Many insurance carriers are requiring PROOF of a history of seeing your family doctor or OB-GYN with complaints of varicose veins, leg pain, and conservative therapy (compression hose) prior to approving medically indicated vein therapy. This varies from one insurance policy to the next. If possible, please request any medical records from your other physicians if this pertains to you. Rest assured that if you have not been seen previously for your veins, we shall assist you in obtaining the best possible coverage for your medical condition.***

VEINHELP
AT SOUTHPOINT

PATIENT REGISTRATION

Name: ______________________ Date: ______________________
Address: ______________________ Home Phone: ______________________
______________________ Work Phone: ______________________
City: __________ State: _____ Zip: __________ Occupation: ______________________
Social Security Number: ______________________ Date of Birth: ______________________
Employer: ______________________
Marital status: S M D W
Spouse (or guardians name) ______________________ Work Phone: ______________________
Nearest Relative: ______________________ Home Phone: ______________________
Who should we contact in case of Emergency? ______________________
Home Phone: ______________________

Primary Insurance Co. ______________________ Phone: ______________________
Policy Holder's Name: ______________________
Policy Holder's Date of Birth: ______________________ Relationship: ______________________
Address: ______________________
Policy or Contract Number: ______________________

Secondary Insurance Co. ______________________ Phone: ______________________
Policy Holder's Name: ______________________ Relationship: ______________________
Address: ______________________
Policy or Contract Number: ______________________

Person responsible for this account:
Name: ______________________ Phone: ______________________
Address: ______________________ Employer: ______________________
______________________ Work Phone: ______________________

Who referred you to our office?
Name: ______________________
Address: ______________________

How did you hear about our office? (Please Check)
☐ A Physician: ______________________
☐ Brochure ☐ Seminar ☐ Internet ☐ Friend
☐ Radio - which station? ______________________
☐ TV - which station? ______________________
☐ Magazine - which one? ☐ So Living ☐ Today's Charlotte Woman ☐ Our State ☐ Other ______________________
☐ Newspaper – which one? ☐ Observer ☐ Herald Sun ☐ N&O ☐ Other ______________________
☐ Other: please describe:
____

For office use only:
Name Patient Prefers: ______________________ Primary Language spoken (if not English) ______________________

VEINHELP AT SOUTHPOINT

MEDICAL HISTORY

YES/NO PLEASE CHECK

☐ ☐ High Blood Pressure
☐ ☐ Heart Disease
☐ ☐ Phlebitis

YES/NO

☐ ☐ Pulmonary Embolus
☐ ☐ Bleeding Disorder
☐ ☐ Blood Clots

YES/NO

☐ ☐ Hepatitis
☐ ☐ Seizures
☐ ☐ Diabetes

Other ________________

Surgical History (LIST ALL SURGERIES) ________________

Medications you are taking ________________

Are you on hormone therapy; estrogen, premarin, provera, birth control etc.? ________________

Are you pregnant or actively trying to get pregnant? YES☐ NO☐

Allergies / Sensitivities (drugs and foods) ________________

Do you have ? (Please Check)

☐ Leg Pain
☐ Tenderness
☐ Aching / Throbbing
☐ Burning / Stinging
☐ Tired / Heavy Legs
☐ Leg Cramps
☐ Itching
☐ Swelling
☐ Skin Changes
☐ Red / Warm Areas
☐ Ulcers/ Ulceration
☐ Other ________________

How many years have you had this problem? ________years

YES/NO PLEASE CHECK

☐ ☐ Related to Pregnancy?
☐ ☐ Related to a Leg Injury?
☐ ☐ Are you developing New Veins?
☐ ☐ Are your present veins getting bigger?
☐ ☐ Is your discomfort/pain getting worse?
☐ ☐ Do you ever take any medication for your leg pain/veins?
aspirin, advil, motrin, ibuprofen, other For How Long?
☐ ☐ Does your discomfort/leg pain interfere with your activities of daily living?
☐ ☐ Have you ever worn stockings for your veins? For How Long?
☐ ☐ Did they help your symptoms (leg pain / swelling)?
☐ ☐ Have you ever seen another physician about your veins?

Are your symptoms worse with?

☐ prolonged standing / sitting
☐ menstrual cycle
☐ not baths or saunas

Are your symptoms relieved with?

☐ rest / elevation of leg

PHYSICIANS NAME ________________

Additional comments: ________________

Family History of Varicose Veins / Spider Veins / Phlebitis / Blood Clots (Please circle which relatives have had any of these.)

mother father sister brother grandmother grandfather uncle aunt none

Previous Vein Treatment History:

☐ Surgery ☐ Laser
☐ Injections ☐ Other ________________

Family Physician ________________ **phone number:** ________________

Address: ________________

Who referred you to our office? ________________

By signing below, I also consent to the taking of photographs for my medical records.

________________ ________________

Patient's Signature **Date**

AUTHORIZATION FOR RELEASE
OF INFORMATION TO FAMILY AND/OR FRIENDS

Name of Patient: ______________________________ **Date of Birth:** ____________________

I authorize Vein Help of the Triangle at Southpoint, (Vein Help) to release protected health information to the entities named below:

Give information to spouse: ☐ Yes ☐ No ☐ N/A

name of spouse: ______________________________

Give information to a family member or friend, please list: ______________________________

____

Contact me at work: ☐ Yes ☐ No ☐ N/A

Vein Help will send correspondence regarding your condition and care to the referring or family physician as noted in your chart unless you check this line: ☐ No please do not release info to family physician

Description of Information to be released to family or friend:

Financial/Billing: ☐ Yes ☐ No

Medical information: ☐ Yes ☐ No

Please list any restrictions regarding information to be released: ______________________________

____

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Vein Help. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective immediately upon receipt of notification by Vein Help.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization.

______________________________ Date ____________________

Signature of Patient or Personal Representative

____

Description of Personal Representative's Authority (attach necessary documentation)

5015 Southpark Drive, Suite 100 ● Durham, NC 27713 ● (919) 405-4200 phone ● (919) 405-4210 fax ● (866) VEIN-HELP toll free
www.veinhelp.com