VEIN ENVY

Patient Registration Form

Last Name:_____ First Name:_____ MI:_____
Address:_____
City:_____ State:_____ Zipcode:_____
Home Phone:_____ Work Phone:_____ Cell Phone: _____
Email:_____
Date of Birth: _____ Sex: ☐ M ☐ F Marital Status : ☐ S ☐ M ☐ D ☐ W
Social Security #: _____-____-_____

Employer:_____ Status : ☐ Full ☐ Part ☐ Retired
Family Physician:_____ Phone #:_____
Referring Physician:_____ Phone #:_____
Emergency Contact: _____
Name **Phone #** **Relationship**

Primary Insurance
Plan Name:_____
Policy Holders Name:_____
Policy Holders DOB:_____
Relationship:_____
Is this an: ☐ HMO ☐ PPO Copay: $_____
ID#_____ Group #_____

Secondary Insurance Plan Name:
Plan Name:_____
Policy Holders Name:_____
Policy Holders DOB:_____
Relationship:_____
Is this an: ☐ HMO ☐ PPO Copay:$_____
ID#_____ Group#_____

Preferred Pharmacy:_____
Name Crossroads
Is English your main language? ☐ Yes ☐ No If No, please specify :_____

How did you hear about us? ☐ Physician Referral ☐ Instagram ☐ Facebook
☐ Sonoran Living ☐ Commercial ☐ Google ☐ Insurance
☐ Family/Friend (Please list name below)

Please Specify:_____

Patient Name:_____ Signature :_____ Date:_____

VEIN ENVY

Patient Name:_____ **Date of Birth:**_____

Check any leg symptom that may apply to you:

☐Aching/Pain ☐Leg bleeds ☐Burning
☐Cramps/Soreness ☐Heavy/Tiredness
☐Itching ☐Numbness ☐Restless Legs
☐Spider Veins ☐Swelling ☐Skin Color Changes
☐Tingling ☐Throbbing ☐Ulcer(s)
☐Varicose Veins ☐Other:_____
Right Leg Severity ☐Mild ☐Mod ☐Severe
Left Leg Severity ☐Mild ☐Mod ☐Severe

Occupation: ☐Retired _____
Prolonged: ☐Sitting ☐Standing

Leg Problems How Long? _____

Symptoms are Worst ☐Daytime ☐Nighttime
☐Both ☐Varies Other _____

Activity of Daily Living Adversely Affected
☐Work ☐Chores ☐Care for Family ☐Travel
☐Stairs ☐Heavy Lifting ☐Shopping ☐Exercise
☐Rising up from Sitting ☐Walking Around
☐Gardening ☐Immobility

Symptoms Made Worse by
☐Walking ☐Exercise ☐Prolong Sit/Stand ☐Heat
☐Hot Baths ☐Premenstrual ☐Pregnancy ☐Travel
Other _____

Symptoms Made Better By
☐Pain Medication ☐Resting ☐Leg Elevation
☐Massaging the leg(s) ☐Exercising ☐Compression
Other _____

Compression Stocking Use
Have you worn compression stockings? ☐Yes ☐No
How long?_____

Strokes, ALS, Parkinsons, Dementia ☐Yes ☐No
Have you experienced a fall in the past 12 months? Y ☐ N ☐

Advance Directive (age 65+)
Mandatory please fill in below
Do you have an Advance Directive, Living Will, or Healthcare Proxy?
☐ **Yes**
☐ **No**—I've been offered information about advance directives and do not wish to name a decision-maker at this time.

I Have Tried the Following :
☐Leg Elevation ☐Exercise ☐Weight Reduction
☐Avoiding Prolonged Sitting/Standing
☐Warm or Cold Soaks ☐Walking ☐Medications

Additional Symptoms
☐Pelvic Pain ☐Pain with Intercourse ☐Hip Pain ☐Back Pain ☐Lower Abdominal Pain

Pertinent Medical Leg History
☐Bleeding disorder ☐ Leg Ulcers ☐Leg Injury
☐Superficial Clots ☐Deep Clots
☐Inflammation ☐Infections ☐Hip/Knee Surgery
☐Which Leg? ☐Left ☐Right
Other _____

Prior Vein Treatment(s) ☐Yes ☐No
Treatments _____
Dates/Location _____

Prior or Current Medical Conditions
Check all that apply to you:
☐No Issues ☐High Blood Pressure
☐High Cholesterol ☐Heart Attack
☐Diabetes ☐Cancer, type? _____
Other _____
_____

Previous Surgeries ☐None Dates:
_____
_____
_____
_____

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Check all that apply to you:
Caffeine: ☐Never ☐Occasional ☐Daily
Drink Alcohol: ☐Never ☐Former ☐Daily ☐Social
Smoke: ☐Never ☐Former, Quit ____mo/yrs ago
Occasionally, How often/How many? _____
☐Daily, ____ packs/day

Have you ever been pregnant? ☐ Yes # _____

Do you have any allergies to medications?
☐No ☐Yes
If yes, to what?_____
Adhesive Allergy? ☐No ☐Yes _____
Steroid Allergy? ☐No ☐Yes _____
Lidocaine Allergy? ☐No ☐Yes _____

Medications: ☐**None**
_____
_____
_____
_____
_____
_____
_____

Review Of Systems

Constitutional Symptoms ☐No Complaints
☐Fever ☐Chills ☐Weight gain/loss
Eyes ☐No Complaints
☐Blurred Vision ☐ Double Vision
Ears, Nose, Mouth,Throat ☐No Complaints
☐Hearing loss ☐Ear Pain ☐Dizziness
☐Jaw Pain ☐Neck Swelling ☐Tinnitus
Cardiovascular ☐No Complaints
☐Chest Pain ☐Lightheadedness
☐Syncope ☐Palpitations
Respiratory ☐No Complaints
☐Cough ☐Dyspnea ☐Wheezing

Family History ☐None
☐Varicose Veins ☐Leg Ulcers ☐DVT ☐PE
☐Hypertension ☐Heart Disease
Circle Mother, Father, Sister, Brother, Grandparents
Other _____
Gastrointestinal ☐No Complaints
☐Abdominal Pain ☐Nausea ☐Diarrhea
☐Constipation
Genitourinary ☐No Complaints
☐Pelvic Pain ☐Difficulty Urinating ☐Genital Pain
☐Pelvic Pressure
Musculoskeletal ☐ No Complaints
☐Neck Pain ☐ Joint Pain ☐Muscle Cramps
Skin/ Breast ☐No Complaints
☐Rash ☐Breast Pain ☐Hair Loss
☐Skin Change
Neurological ☐No Complaints
☐Headaches ☐Seizures ☐Fainting
Psychiatric ☐No Complaints
☐Depression ☐Anxiety ☐Excess Energy
☐Insomnia
Endocrine ☐No Complaints
☐Excessive Thirst ☐Excessive Heat/Cold
Sensitivity
Hematologic ☐No Complaints
☐Anemia ☐Easy Bleeding ☐Fatigue
☐Recurrent Infections
Immunologic ☐No Complaints
☐Hives ☐Throat Itching ☐Eye Redness
☐Difficulty Swallowing

Is there any other medical history that we should be aware of? Please explain below
_____
_____
_____
_____
_____

Physician Signature:_____

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Medical Practitioner Only ----------

Physical Exam: _____

CEAP Clinical Signs:_____

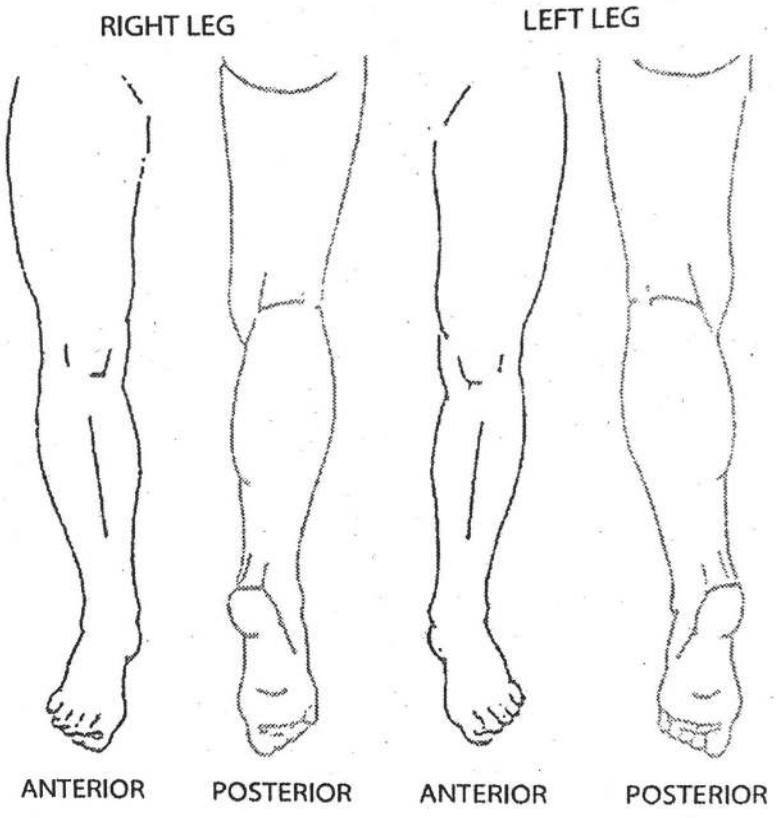
Right Leg	**Left Leg**
☐ No Signs of Veins	☐ No Signs of Veins
☐ Active/Healed Ulcer(s)	☐ Active/Healed Ulcer(s)
☐ Edema	☐ Edema
☐ Pigmentation	☐ Pigmentation
☐ Varicose Veins	☐ Varicose Veins
☐ Spider Veins	☐ Spider Veins

Clinical Assessment:

Chronic Venous Insufficiency Leg: ☐ Right ☐ Left

Treatment Plan:

☐ Ultrasound ☐ Compression Stockings ☐ Sclerotherapy



Patient Name:_____ Date of Birth:_____

Vein Envy Financial Policy

Please carefully read and initial each statement and sign below.

This policy has been put in place to ensure that financial payments due are recovered, allowing us to continue to provide quality medical care for our patients. It is important that we work together to assure that payments for services are as simple and straightforward as possible. Our billing department will be glad to discuss these policies with you.

1. _____ I understand that if I do not have my insurance card, referral and/or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments. I also authorize the assignment of insurance benefits to Vein Envy

2. _____I understand that if my account is not paid in full, my account will be turned over to a third-party collections company for further processing and I will be responsible for paying any collection fee incurred by the practice. Any such fees will be added to the outstanding balance owed. No additional appointments will be made for delinquent accounts until they are brought current. Proof of a zero balance is required when presenting for care.

3. _____I understand that if I am unable to make a scheduled appointment, I need to contact Vein Envy at least **24 hours** before my scheduled appointment time. If a patient misses 2 visits, Vein Envy reserves the right to discontinue the provider-patient relationship. A letter will be sent to the patient notifying you of such a change.

4. _____It is my responsibility to provide correct insurance information and notify Vein Envy if there is a change in my insurance coverage, residence, or phone number. It is also my responsibility to provide my insurance company with any information that may be requested by them in order to process a claim for services. If a claim is denied by insurance because I did not provide the correct insurance information or respond to any information requests in a timely manner. I understand that I will be financially responsible for any and all treatment(s) received. I understand that in the event my insurance denies any claim, I will agree to pay the amount owed in full or arrange for a payment plan to satisfy the balance due.

5. _____ **I understand that if I fail to show for my appointment, or do not reschedule my appointment 24 hours prior to the appointment time, there will be a $50.00 charge added to my account. If I fail to show for my procedure, there will be a $100.00 charge added to my account. I understand that it is my responsibility to be fully aware of my appointment times.**

6. _____ I have read and I understand the above Financial Policy and I agree to abide by its terms.

_____ _____

Patient Name Signature of Patient/Responsible Person

_____

Date

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Patient Name:_____ **Date of Birth:**_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I (Patient Name Printed) _____ acknowledge that I have been offered a copy of VEIN ENVY “Notice of Privacy Practice”. This notice describes how Vein Envy may use and disclose my protected health information, certain restrictions on the use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

(Signature of Patient, or Personal Representation) (Date)

_____

(Relationship to Patient)

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Patient Photo Release Consent

I hereby authorize Dr. Ryan Jones/ Vein Envy and staff to use my photos for any information contained herein office relations efforts. I understand and approve the disclosure of the photos and information to the Vein Envy office. I acknowledge that this form does not give Vein Envy the legal permission to release my photos to any media for any purpose.

I understand that I am providing the photos and information to Dr. Ryan Jones/ Vein Envy and that my treating healthcare provider will not be providing any protected information to the media, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

☐ I authorize Vein Envy to take before and after photos of my legs for my personal chart records for the purpose of comparing my treatment results.

Print Name: _____ Date:_____

Patient Signature: _____