NORTHWEST Vascular and Vein Specialists

Date: _____

PATIENT REGISTRATION FORMS

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

SS #: _____ **Gender Identity:** Male / Female / Other _____

Marital Status: ✡Single ✡Married ✡Separated ✡ Divorced ✡Widowed

Home Ph#: _____**Cell Ph#:** _____ **Work Ph#** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

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 to grant you access to your medical records via our online portal)

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

How did you hear about us? _____

Emergency Contact Name: _____**Ph#**: _____**Relationship:** _____

Social History:

Occupation: _____ Employer: _____

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

Who do YOU live with: ✡Self ✡Spouse ✡Other _____

Do you drive: ✡Yes ✡ No Do you have stairs in your home: ✡No ✡Yes

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? ✡No ✡ Yes - How often? _____

Patient Signature: _____ Date: _____

Date: _____

PATIENT MEDICAL HISTORY

Last Name: _____ DOB: _____ Height: _____ Weight: _____

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)
☼Deep Vein Thrombosis (DVT)
☼Diabetes
☼Gastro-esophageal Reflux Disease (GERD)
☼High Blood Pressure
☼High Cholesterol
☼History of Phlebitis
☼Heart Disease: Coronary Artery Disease- CAD
Congestive Heart Failure- CHF
Myocardial Infarction- Heart Attack
☼Hepatitis
☼Kidney disease (Renal Failure)
☼Leg Ulcers
☼Liver Disease (Cirrhosis)
☼Lumbar Spine Disease (Back Problems)
☼Lymphedema/Leg Swelling
☼Migraines
☼Neuropathy
☼Pacemaker/AICD
☼Peripheral Arterial Disease (PAD)
☼Prostate Disease
☼Raynaud's Disease Syndrome
☼Stroke/TIA
☼Thyroid Disease
☼Other _____
☼Other _____
☼Other _____

Medication List (Please include dosage and start date) _____
_____ _____
_____ _____

Surgical History (check all that apply and <u>list date</u>):

☼Heart Bypass (CABG)
☼Appendectomy
☼Gallbladder Surgery
☼Back Surgery
☼Hysterectomy
☼Breast Surgery
☼Cataracts
☼Varicose Vein Surgery
☼Heart Angioplasty
☼Tonsillectomy
☼Foot Surgery
☼Other: Please specify: _____
Have you had any recent Hospitalizations within the last 6 months? ☼No ☼Yes, Cause: _____

Allergies and Reactions *INCLUDE LATEX_____

Family History:

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

<u>65 and older only</u>: Do you have an Advanced Care Plan in place? Yes ____ No ____

If yes, who is your surrogate decision maker? Name: _____ Contact# _____

Patient Signature: _____ Date:_____

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 Doppler study done to evaluate your veins? □ Yes □ No
   Where/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 □Other _____
6. Have you ever had phlebitis (surface blood clot)? □ 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
Tingling?	□ 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. Do you stand for long periods at work? (If yes, how long? _____) □ Yes □ No

Patient Signature: _____ Date:_____

NORTHWEST
Vascular and Vein Specialists

Financial/Insurance Acknowledgement

As a courtesy, we will bill your insurance on your behalf, provided that you supply all of the correct and necessary information at the time of service. Any services that are not paid by your insurance will become your financial responsibility. Due to the many insurance plans that our provider is contracted with, it is not possible for us to know the specifics to your plan. We ask that our patients familiarize themselves with their insurance; coverage, covered services, benefit levels, out of network benefits, etc. Please notify our front desk staff if you are aware that certain services are not covered and be prepared to make payments for those services on the day of your appointment.

I understand that I am financially responsible for all services received. If using insurance, I am responsible for any and all office visit copays, procedure costs, and any balance that remains after claims are processed. Any past due balances that lapse over a 3-month period **will be sent to a collection agency.**

If I am not using insurance, I understand that payment is due at the time of my appointment and the cost of services have been discussed with me at the of scheduling.

No Show/Cancellation Policy
We understand that you may need to cancel or reschedule an appointment due to an emergency or other obligation. However, not notifying us of this prior to your appointment can potentially be preventing another patient from getting much needed treatment. We hope that our time is valued as much as we value yours. We ask that you notify us if you need to cancel or reschedule, **AT LEAST 24 hours** in advance. Failure to do so will result in a fifty-dollar **($50.00)** fee **($100.00** for procedures). This fee will automatically be applied to your account, resulting in a balance to which you are responsible.

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.

Patient Signature: _____ Date: _____

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

And/Or: Name_____ Relationship: _____ Contact#: _____

Messages may be left on my answering machine or voicemail **including test results**: □ Yes □ No

Messages may be left with one of the people listed above: □ Yes □ No

Can we send you text messages at the number you have provided? □ Yes □ No

Patient Signature: _____ Date: _____