New Patient Registration Form ***Today Date*** ___/___/___ **MD**

Patient Name: (Last, First, Middle)		Age	Date of Birth / /
Social Security #	Sex M F *Please circle one*	Marital Status S M D W *Please circle one*	
Preferred Language: English Spanish Other: *Please circle one*	Race: Amer.Indian, Asian, Black, Caucasian, Other, Declined *Please circle one*		
	Ethnicity: Hispanic, Non-Hispanic, Declined *Please circle one*		
Street Address			
City	State	Zip	
Home #	Work #	Cell #	

Employment Information

Employer Name	Occupation
Employer Address	Phone #

City	State	Zip

Key Medical And Lifestyle Information

Major Complaint (*describe pain or concern*)	Family History of Varicose Veins?
Hobbies	

City	State	Zip

Emergency Contact-Residing at Different Address

Name	Phone #	Relationship

Patient e-mail address:

VEININNOVATIONS

New Patient Medical History

Patient Name: _____

Office Visit Date: _____ ***DOB:***_____ ***Gender:*** **Male / Female**

Age:_____ ***Height:*** _____ ***Weight:***_____

Reason for Visit:_____

CHECK ALL APPLICABLE SYMPTOMS:

	Right Leg	Left Leg
Varicose Veins Present	☐	☐
Spider Veins Present	☐	☐
Pain in Thigh and/or Calf	☐	☐
Swelling in Leg and/or Foot	☐	☐
Fatigue and/or Heaviness in Leg	☐	☐
Burning and/or Itching	☐	☐
Night Cramping/Restless Leg	☐	☐
Severe Discoloration/Ulcer Present	☐	☐
Bleeding from Varicose Vein	☐	☐

Do Any of Your Symptoms Interfere with… **Occupation?** **Yes / No**
Daily Activities? **Yes / No**
Sleep Habits? **Yes / No**

Do Any of Your Symptoms Improve with... **Medical Stockings?** **Yes / No**
Exercise/Walking? **Yes / No**
Medication? **Yes / No**
Leg Elevation? **Yes / No**

Do You Have a Family History of Spider/Varicose Veins? **Yes / No**

Have You Had a Previous Ultrasound of Your Leg Veins? **Yes / No**
Date: Location:

Have You Had Any Previous Treatment to Your Leg Veins? **Yes / No**
Date: Location:
List Treatment Type(s):

Have You Worn Medical-Grade Compression Stockings? **Yes / No**
If So, Circle Type of Stockings: Prescription Grade / Self-Purchase
Estimated Date & Duration Worn:

CHECK ALL APPLICABLE MEDICAL CONDITIONS:

Deep Vein Thrombosis (DVT)	----------	☐
Superficial Thrombophlebitis	----------	☐
Pulmonary Embolism	----------	☐
Hypercholesterolemia	----------	☐
Hypertension	----------	☐
Cardiac Disease	----------	☐
Peripheral Vascular Disease	----------	☐
Fainting/Syncope	----------	☐
Diabetes Mellitus (Type I/Type II)	----------	☐
Kidney Disease	----------	☐
Arthritis	----------	☐
Lumbar Spine/Disk Degeneration	----------	☐
Cancer	----------	☐
Auto-Immune Disorder	----------	☐
HIV/AIDS	----------	☐
Hepatitis	----------	☐
Other		☐

Do You Smoke? **Yes / No** Amount:
Do You Drink Alcohol? **Yes / No** Amount:
Do You Exercise Regularly? **Yes / No** Amount:

Known Allergies: ___

Prior Surgical History:

Current Medications:

Any Past History of Significant Leg Trauma or Injury? **Yes / No**

If So, Did You Sustain Bone Fracture and/or Require Surgery? **Yes / No**

Circle Type of Trauma/Injury Fall / Motor Vehicle Accident / Impact / Other

Estimated Date of Trauma/Injury: _____

FEMALES ONLY:

Currently Pregnant: **Yes / No**
Currently Breastfeeding: **Yes / No**
Current Hormone Therapy: **Yes / No**
Post-Pregnancy Varicose/Spider Veins: **Yes / No**
Planning Additional Childbirths: **Yes / No**
Total Number of Full-Term Pregnancies: _____

CLINICAL STAFF ONLY: ***VITAL SIGNS*** Blood Pressure: _____ Pulse: _____

PHOTOS OBTAINED Date: _____

MGCS RX ISSUED Duration: _____ Insurer: _____

VEININNOVATIONS

Authorization for Release of Information to Primary Care Physician

Patient Name:_____ DOB:_____

*I authorize **VEIN**INNOVATIONS to release records to my:*

☐ Primary Physician: _____

Name

_____

Address

_____

City, State, Zip

_____ _____

Phone number **Fax number**

☐ I do ☐ I do not ☐ N/A… Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)

This authorization will expire one year after it is signed

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule. I have the right to revoke this authorization in writing except to the extent that Vein Innovations has acted in reliance upon this authorization. My written revocation must be submitted to Vein Innovations Privacy Officer at 5673 Peachtree Dunwoody Rd #340, Atlanta, Ga. 30342 Phone #678-731-9815

By signing this authorization, I authorize Vein Innovations to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed above.

***Signature*: _____ *Date*: _____**

VEININNOVATIONS

Authorization for Release of Information to Referring Physician

Did your primary care refer you to our practice? ☐ **Yes** ☐ **No**

Did a specialist refer you to our practice? ☐ **Yes** ☐ **No**

If yes, please complete the entire form:

Patient Name_____ DOB_____

*I authorize **VEIN**INNOVATIONS to release records to my:*

☐ Referring Physician: _____
Name

_____
Practice Name

_____
Address

_____
City, State, Zip

_____ _____
Phone number **Fax number**

☐ I do ☐ I do not ☐ N/A… Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)

This authorization will expire one year after it is signed

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule. I have the right to revoke this authorization in writing except to the extent that Vein Innovations has acted in reliance upon this authorization. My written revocation must be submitted to Vein Innovations Privacy Officer at 5673 Peachtree Dunwoody Rd #340, Atlanta, Ga. 30342 Phone #678-731-9815

By signing this authorization, I authorize to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed above.

***Signature*: _____ *Date*: _____**