THE VEIN CLINIC
OF WASHINGTON

Name: _____ Date of Birth: _____

Home address: _____

City: _____ State: _____ Zip: _____

Preferred Telephone: (_____) _____ ___Mobile ___Home ___Work

Alternate Telephone: (_____) _____ ___Mobile ___Home ___Work

Email address: _____

Social Security Number (optional): _____

Emergency contact and telephone: _____

Who referred you to our practice? _____

Reason for consultation? _____

I acknowledge that I am responsible for services rendered, and not my insurance company. I agree to pay in full at the time of service unless other arrangements have been made. In the event service rendered is billed to a third party, I authorize payment to be paid directly to the physician.

I hereby authorize you to release my medical information when appropriate (for medical and/or insurance purposes only). I also authorize you to request copies of my medical records from other physicians and/or medical facilities in conjunction with my care.

A copy of the HIPAA privacy practice has been made available to me. I understand that it will be updated every year and will be made available to me upon request.

Signature: _____ Date: _____

Medical History

Patient's name: _____ Date of Birth: _____

Height: _____ ft _____inches Weight: _____ lbs. Sex: □male □female

Primary care physician: _____

Other physicians: _____

Past Surgeries? _____

Please list all medications you are taking: _____

_____

Please check the boxes below if you have ever had any of the following:

□ asthma	□ thyroid problems	□ jaundice
□ heart disease	□ stroke	□ shortness of breath
□ cancer	□ glaucoma	□ severe headaches
□ liver problems	□ hernia	□ urinary difficulty
□ bleeding problems	□ seizures	□ swelling of legs
□ blood clots	□ diabetes	□ other:_____

Does your work require long periods of standing or sitting? □Yes □No

Do you smoke? □Yes □No
If yes, how frequently? _____

Do you exercise regularly? □Yes □No
If yes, how frequently? _____

Do you drink alcohol? □Yes □No
If yes, how frequently? _____

Do you or have you used any recreational drugs? □Yes □No
If yes, how frequently? _____

Do you have any drug allergies? □Yes □No
If yes, how frequently? _____

Do you have an allergy to latex? □Yes □No

Are you pregnant or ever been pregnant? □Yes □No

Have you ever had a blood transfusion? □Yes □No

Please CIRCLE any of the following symptoms you are experiencing in your legs:

Aching	R/L	Itching	R/L	Tiredness	R/L
Throbbing	R/L	Fatigue	R/L	Leg Cramps	R/L
Pain	R/L	Restless Legs	R/L	Swelling/Swollen Ankles	R/L
Heaviness	R/L	Burning	R/L	Skin or Ulcer Problems	R/L

Do any of these symptoms circled previously interfere with your daily activities? □Yes □ No

Have you ever had to take medication for the pain? □Yes □ No

Do you elevate your legs? □Yes □ No

Have you worn compression stockings? □Yes □ No
a. If yes, for how long?_____
b. Were they prescribed or suggested by a physician?_____

Have you ever had a phlebectomy or vein stripping? □Yes □No

If yes, when and which leg? _____

Have you ever had vein injections, sclerotherapy, or laser therapy? □Yes □ No

If yes, when and which leg? _____

Have you ever had Endo Venous Laser or RF ablation treatment? □Yes □ No □ Not Sure

If yes, when and which leg? _____

Have you ever had a blood clot? □Yes □ No

If yes, when and which leg? _____

Have you ever had phlenitis (redness or tenderness of vein)? □Yes □ No

If yes, when and which leg? _____

Have you ever been diagnosed with venous insufficiency or reflux? □Yes □ No

If yes, when and which leg? _____

Have you ever been diagnosed with a coronary artery disease, peripheral, arterial disease, carotid arterial disease, or diabetes mellitus? □Yes □ No

If yes, please list:_____

Constitutional Symptoms:

Good general health	Y	N
Recent weight change	Y	N
Fever	Y	N
Fatigue	Y	N
Headaches	Y	N

Eyes:

Eye Disease or Injury	Y	N
Wear glasses or contacts	Y	N
Blurred or double vision	Y	N
Glaucoma	Y	N

Ears|Nose|Throat:

Hearing loss or ringing	Y	N
Earaches or drainage	Y	N
Chronic sinus problems	Y	N
Nose bleeds	Y	N
Mouth sores	Y	N
Bleeding gums	Y	N
Bad breath or taste	Y	N
Sore throat or voice change	Y	N
Swollen glands in neck	Y	N

Cardiovascular:

Heart trouble	Y	N
Chest pain or angina pectoris	Y	N
Palpitation	Y	N
Short of breath while walking	Y	N

Respiratory:

Chronic or frequent cough	Y	N
Spitting up blood	Y	N
Shortness of breath	Y	N
Asthma or wheezing	Y	N

Gatrointestinal:

Loss of appetite	Y	N
Change in bowel movement	Y	N
Nausea or vomiting	Y	N
Frequent diarrhea/constipation	Y	N
Rectal bleeding/blood in stool	Y	N
Abdominal pain	Y	N
Peptic ulcer	Y	N

Genitourinary:

Frequent urination	Y	N
Burning or painful urination	Y	N
Blood in urine	Y	N
Kidney stones	Y	N
Irregular periods (female)	Y	N

Musculoskeletal:

Join Pain	Y	N
Joint stiffness or swelling	Y	N
Weakness of muscle or joints	Y	N
Back pain	Y	N
Cold feet or hands	Y	N
Difficulty walking	Y	N

Integumentary (skin)

Rash or itching	Y	N
Change in skin	Y	N
Varicose veins	Y	N
Breast pain/lumps/discharge	Y	N

Neurological:

Frequent/recurring headaches	Y	N
Convulsions/Seizures	Y	N
Numbness/tingling sensation	Y	N
Tremors	Y	N
Paralysis	Y	N
Stroke	Y	N
Memory loss/confusion	Y	N
Head injury	Y	N

Psychiatric:

Nervousmess	Y	N
Depression	Y	N
Insomnia	Y	N

Endocrine:

Glandular/hormonal problem	Y	N
Thyroid disease	Y	N
Diabetes	Y	N
Excessive thirst/urination	Y	N
Heat or cold intolerance	Y	N

Hematologic|Lymphatic:

Slow to heal after cuts	Y	N
Bleeding or bruising tendency	Y	N
Anemia	Y	N
Phlebitis	Y	N
Past Transfusion	Y	N
Enlarged glands	Y	N

Allergies|Immunologic:

History of skin or adverse reactions to:

Penicilin or other antibiotics	Y	N
Asprin or other pain remedies	Y	N

Other: _____

Family Medical History (Please list any important health related issues past or present):

Mother:_____

Father:_____

Children:_____

Sibling:_____

Grandfather:_____

Grandmother:_____

Does anyone in your family have or used to have:

□varicose veins
□ spider veins
□ leg ulcers
□ swollen legs
□ vein stripping
□ phlebectomy
□ sclerotherapy
□ laser therapy
□ blood clots
□ pulmonary emboli
□ endo venous laser
□ RF ablation treatment
□ blood coagulation disorder
□ stroke
□ heart attack

If yes to any, please list who:_____

I certify that the above statements are true to the best of my knowledge and understand it is my responsibility if to notify The Vein Clinic of Washington of any changes to my medical history.

Patient Signature:_____ Date:_____

THE VEIN CLINIC
OF WASHINGTON

Financial Policy

Dr. Samir Neimat and staff would like to welcome you to The Vein Clinic of Washington. The goal of our medical practice is to provide you with the comprehensive, convenient and above all, quality care. Our office believes the relationship between your health care provider (Dr. Neimat) and yourself requires mutual respect, consideration and understanding. We ask that you please honor that relationship by taking care of your financial commitment in a timely manner.

Please initial the following:

_____We have submitted applications for participation to all major insurance companies and already participate with some of them. However, it is the patient's responsibility to ensure that the physician he/she is seeing is listed with the insurance company as a participating provider. Any patient treated by a non-participating physician will be responsible for any deductibles, co-insurance, uncovered services, etc., imposed by their insurance company. From time to time we may ask you to assist us in obtaining payment from your insurance company on claims that have remained unpaid for an extended period of time.

_____Payment of the office visit or your appropriate co-payment is due the day of service; additional fees are due within 30 days of adjudication of your claim. We accept cash, personal checks, Visa, MasterCard and Discover. All returned checks will be assessed a $30.00 returned check fee in addition to the original charge.

_____Any additional co-payments, deductibles and/or co-insurance will be billed to the patient as indicated by your insurance carrier on their Explanation of Benefits (EOB). Your insurance company will mail you an EOB outlining the services rendered and the portion of the bill which is your responsibility. All patients without insurance must pay in full at the time services are rendered.

_____With the many changes that happen in health plans (claims addresses, group numbers, covered services, network changes) it is important to keep our staff notified. Failure to produce proper insurance coverage identification or information may result in your being responsible for services.

_____ANY CANCELLATIONS REQUIRE 24 HOURS NOTICE. THERE WILL BE A $30.00 CHARGE FOR ANY CANCELLATIONS MADE LESS THAN 24 HOURS. THIS CHARGE IS NOT REIMBURSABLE BY INSURANCE.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, Blue Shield, HMO plans and commercial insurance to The Vein Clinic of Washington. I understand that I am financially responsible for all the charges whether or not covered by said insurance. I hereby authorize said assigned to release any information necessary to secure payment on my behalf.

Patient Signature:_____ Date:_____