Acct#________________

Advanced Vein and Vascular Associates

8210 Walnut Hill Lane
Suite 408
Dallas, Texas 75231
469-547-1142

4708 Alliance Blvd.
Suite 835
Plano, Texas
469-547-1142

1105 N. Central Expressway
MOB 2, Suite 2310
Allen, Texas 75023
469-547-1142

Patient Information

Last:______________________________First:___________________________M:______Sex:______DOB:___________Age:_____
Address:____
Home Phone:____________________________Cell: _____________________________Work:___________________________
Social Security #:____________________________
Employer:____Occupation:___________________________
Employer Address:____

Spouse Information
Last:______________________________First:___________________________SSN:______________________DOB:__________
Employer:____Occupation:___________________________
Work #:____

Emergency Contact(someone who does NOT live in the house)**:**
Last:______________________________First:___________________________Relationship:__________________________
Address:____Phone #:_____________________________

Insurance Information

Primary:____Phone #:_____________________________
Address:____
Insured Name:____DOB:_____________________
Relationship to Patient:____
Policy #:____Group #:___________________________________
Secondary:____Phone #:_____________________________
Address:____
Insured Name:____DOB:_____________________
Relationship to Patient:____
Policy #:____Group #:___________________________________

PCP/Family Physician:____Phone #:__________________________
Referring Physician:____Phone #:__________________________

Was this injury/illness the result of an accident? ________Yes________No
Where did it occur?________Work_______Auto________Other
Date of Accident:______________________Has this been reported to your employer? ________Yes________No

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Patient Authorizations

All medical care is provided to you and not your insurance company, therefore, you are responsible for all charges. As a courtesy, we will file your medical insurance for you but we are not responsible for any limitations in coverage that may be included in your plan. The financial responsibility for all medical care is yours. We ask that you question anything you do not understand and we will be happy to answer your questions to the best of our ability. Your insurance company is the best resource for your benefits. Co-payments and deductibles are due at the time services are rendered. If you are uninsured or if the service is not covered by your carrier, you are expected to pay in full at the time of service. If you receive a payment from your insurance company in error for services rendered by AVVA, please bring it to the office or mail it to us with the Explanation of Benefits so we can post it accordingly.

Consent to Treatment
I hereby consent to an evaluation with testing and treatment as deemed necessary by my physician or his designee. ____________Initial

Assignment of Benefits/Patient Financial Responsibility
I authorize direct payment of my benefits to AVVA for services rendered to me or my dependents by my provider. I understand that this is my responsibility to know my benefits and whether or not the services I am to receive are a covered benefit. I agree to Pay any co-pay or balance due after insurance within 10 days of receiving a statement from the provider. ____________Initial

Medicare/Medicaid/Insurance Benefits
I request payment from Medicare/Medicaid or any other insurance company be made on my behalf to AVVA. I authorize release of any of my or my dependents medical records that may be requested by the carrier. I authorize any holder of medical information about me to be released to CMS, Medicaid or insurance company needed to determine benefits payable for services received. ____________Initial

X-ray, Lab or Diagnostic Services
I understand I may receive a separate bill if my medical care includes lab, x-ray or diagnostic services. I understand that I am financially responsible for any copay or balance due for these services if they are not reimbursed by my insurance for any reason. ____________Initial

PLEASE READ CAREFULLY AND SELECT APPROPRIATE RESPONSE

Authorization to release Non-public personal information and witness of HIPPA policy(in waiting room)
I certify that I have read a copy of the Patient Information Privacy Policy. I hereby authorize AVVA to release any of my or my dependents medical or incidental non-public personal information that may be necessary for evaluation, treatment, consultation, or for processing insurance benefits.
____________Initial

I do not wish my information to be disclosed to any person. ____________Initial

I give permission to disclose/discuss any information related to my medical/financial care to the following family members, other relative or close friend.

Name:____Relationship:_____________________________Phone #:____________________
Name:____Relationship:_____________________________Phone #:____________________

Authorization to call, mail or E-mail
I understand the privacy risks of the mail, phone calls and email. I hereby authorize a representative or my physician to mail, call or email me with communications regarding my healthcare, including but not limited to appointment reminders, referral arrangements and lab/x-ray results. I understand that I have the right to rescind this authorization at any time by notifying AVVA in writing. ____________Initial

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information and payment of any services not covered or approved by my carrier.

____ ____
Patient Signature or Authorized Representative Date

Confidential Health & Vascular History

PATIENT INFORMATION:

Name:____
Age:_________Sex:________Height:___________Weight: ____________Years with Varicose/spider veins:____________

HOW DID YOU HEAR ABOUT US:

____
____
Referring Doctor:____

PRIMARY CARE INFORMATION:

Primary Care Physician:____Phone #:___________________

VASCULAR SYMPTOMS & HISTORY:

Please check if you have:

____Red spider Veins Lt_____Rt_____
____Skin discoloration below your knee Lt_____Rt_____
____Purple veins Lt_____Rt_____
____Purple vein network Lt_____Rt_____
____Abdominal veins
____Bulging veins Lt_____Rt_____
____Flat buish-green veins Lt_____Rt_____
____Diagnosis of vein disease Lt_____Rt_____
____Leg ulcer Lt_____Rt_____
____Other:____

Do your legs or ankles:

____Ache or hurt? Lt_____Rt_____
____Swell? Lt_____Rt_____
____Cramp? Lt_____Rt_____
____Become restless? Lt_____Rt_____
____Become tired/heavy? Lt_____Rt_____
____Itch? Lt_____Rt_____
____Other?

Please Describe:
____
____
____
____
____
____
____

Please check any methods you have used to relieve your leg discomfort:

____No Discomfort
____Leg Elevation
____Exercise
____Flexion/Extension of your feet
____Walking
____Support Hose
____Wraps
____Warm Socks
____Cold Packs
____Pain Meds
____Aspirin
____Tylenol
____Ibuprofen
____Other Method:________________________________

Are you on your feet for long periods?_______________In what capacity?____
____

Does walking/exercise relieve your discomfort or make it worse?____
Have you been treated for your veins before?___________
By whom?____When?____

What method?

____Injections Lt_____Rt_____
____Stripping Lt_____Rt_____
____Ambulatory Phlebeotomy Lt_____Rt_____
____Ligation
____Other_______________________
____Ultrasound-Guided Injections Lt_____Rt_____
____Radiofrequencey Closure Lt_____Rt_____
____Laser Catheter Ablation Lt_____Rt_____
____Laser for Spider Veins Lt_____Rt_____

What have your results been?

____
____
____
____
____
____
____
____

MEDICAL HISTORY:

Is there a history in your FAMILY of spider or varicose veins?____________
WHO?____

Is there a history in your FAMILY of deep venous thrombosis, stroke or clotting disorders?____________
WHO?____

Do YOU have a history of:

____Anemia
____Ankle Skin changes
____Atherosclerosis
____Bleeding/Blood disorder
____Chest Pain, discomfort
____Constipation
____Crohn’s disease, IBS
____Deep Vein Thrombosis/clot
____Diabetes; Insulin dependent
____Easy bruising
____Erectile difficulty/dysfunction
____Heart disease
____Hepatitis
____HIV
____Hypertension
____Kidney disease
____Leg ulcers
____Liver disease
____Lupus
____Migraine headaches
____Mitral valve prolapse
____Pulmonary embolus
____Rupture of a vein
____Superficial Thrombophlebitis
____Trauma to your legs
____Other__________________________

CURRENT MEDICAL INFORMATION:

Do you have allergies or sensitivities to medicines or tape? List all:
____

Are you being treated for any illness or conditions? _____________If so, what?_____________________________________
____
____
____

Please list all medications and supplements that you take(Prescription, Non-Prescription, Vitamins, and Herbal):

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

Do you smoke?_______________

What operations have you had?

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

Any complications from your surgery?

____
____
____
____