Section I: **Patient Information** **Date_________________**

*Name : ____

*Address: ______________________________________ APT: ______City:___________________ State: ______ Zip__________

*Phone (______) __________________ Work Phone (_______) ___________________ Cell Phone (______) _________________

Age: _______ *Date of Birth (MM/DD/YY): ____________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

*Email Address: ____ Would you like to receive our e-statement? ☐ Yes ☐ No

*Social Security Number: ________________________ *Gender: ☐ Male ☐ Female

Language Spoken: ☐ Armenian ☐ English ☐ Polish ☐ Russian ☐ Spanish ☐ Other: ____________________________

How did you hear about us? ____

Contact person in case of emergency:__________________Phone:_____________________ Relationship to Patient:__________

May we discuss: Account Balance ☐ Yes ☐ No Treatment Details ☐ Yes ☐ No

Section II: **Insurance Information**

*Policy Holder's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: __________________________

*Name: ____*Date of Birth: ____________________

Address: ____

City: ________________________________ State: __________ Zip:______________ Phone: (______)____________________

Employer:____ * SSN#__________________________

*Insurance Company:______________________________ Grp #________________________ *ID#_______________________

*Ins Co Address: ____ Ins Co. Phone:_______________________________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Name of Insured:___________________________________DOB:________________Relationship to Patient:_______________

SSN#:_________________________ Name of Employer:_________________________ Work Phone: (_____)______________

Insurance Company:____________________________ Grp #________________________ ID#_________________________

Ins Co Address:____ Ins Co. Phone:_______________________________

I hereby authorize the above physician to release any information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance.

____ ______________________

Patient/Guarantor's Signature **Date**

I hereby authorize and direct my insurer to issue payment for benefits for the services rendered to me by the above named physician to be made directly to the physician. Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered.

____ ______________________

Patient/Guarantor's Signature **Date**

Patient Name:

DOB: **Date:**

Patient Health History Form

Please, answer all the questions the best you can so that we can fully understand your medical needs

Chief Complaint

Which leg is experiencing any form of discomfort? Right Left Both

Have you ever had your veins evaluated by a doctor before? YES NO
If yes, what doctor and when? ______________________________

Did the doctor perform any tests (for example, an ultrasound)? YES NO

Do you currently wear a support hose prescribed by a doctor? YES NO
If yes, do they provide relief? YES NO

Do you currently wear light support hose (for example, sheer energy)? YES NO
If yes, do they provide relief? YES NO

Have you ever had any vein surgery? YES NO
If yes, on which leg? Right Left Both

Have you ever had vein injection? YES NO
If yes, on which leg? Right Left Both

Have you ever been diagnosed with a blood clot in your leg? YES NO
If yes, on which leg? Right Left Both

Have you been diagnosed with phlebitis? YES NO
If yes, on which leg? Right Left Both

Do you experience any of the following symptoms in your legs?

Aching/pain	Yes	No	Heel pain	Yes	No
Tiredness/fatigue	Yes	No	Ingrown nails	Yes	No
Swollen ankles	Yes	No	Hammertoes	Yes	No
Restless legs	Yes	No	Plantar warts	Yes	No
Heaviness	Yes	No	Diabetic ulcer	Yes	No
Itching/burning	Yes	No	Toenail fungus	Yes	No
Leg cramps	Yes	No	Flat feet	Yes	No
Throbbing	Yes	No	Bunions	Yes	No
			Tendinitis	Yes	No
			Injury of the foot/ankle	Yes	No

Other ____

How long have you experienced following symptoms? _____ Years _____ Months

How do you relieve the discomfort in your legs? Elevate Walk

Do you take pain medications to relieve symptoms in your legs? YES NO
(for example: Ibuprofen, Tylenol, Advil, Celebrex)
If yes, does the medication help? YES NO

If yes, how long have you been taking it? _________________

Do you stand much at work? How long? _______________ YES NO

Do you stand much at home? How long? _______________ YES NO

Patient Name:

DOB: **Date:**

Past Medical History

Do you have history of any of the following? If yes, please specify:

Heart Disease	Yes	No	Pacemaker	Yes	No
Lung Disease	Yes	No	Anemia	Yes	No
Hepatitis	Yes	No	Arthritis	Yes	No
Leg Ulcer	Yes	No	Diabetes	Yes	No
Asthma	Yes	No	Thyroid	Yes	No
High Blood Pressure	Yes	No	Blood Clot Disorder	Yes	No

Other significant medical history not listed above: ____
____

Who is your regular family physician? ____

Are you presently under the care of this physician for any illness? Yes No
If yes, please explain: ____

Past Surgical History

Type of Surgery	Date
________________________________	______________
________________________________	______________
________________________________	______________
________________________________	______________

Reason for Hospitalization	Date
________________________________	______________
________________________________	______________
________________________________	______________
________________________________	______________

Family History

Have any of your family members ever experienced Varicose Veins? Yes No
If yes, please list below:

Relationship to Patient	Age
________________________________	______________
________________________________	______________
________________________________	______________
________________________________	______________

Social History

What is your profession? ____
Do you smoke? Yes No If yes, how much? ______________________________
Do you drink alcohol? Yes No If yes, how much? ______________________________

Patient Name:

DOB: **Date:**

Women only: Child Bearing History

Are you presently pregnant? Yes No Not Sure
How many times have you been pregnant? __________
Do you intend to have any more children? Yes No Not Sure
Are you currently breast-feeding? Yes No

Medications

Please, list all current medications (prescription & over the counter) you are currently taking:

Medication	Dosage	Frequency
__________________________	________________	________________
__________________________	________________	________________
__________________________	________________	________________
__________________________	________________	________________
__________________________	________________	________________
__________________________	________________	________________

Allergies

Do you have any allergies?	What happens when you are exposed to allergen?
__________________________	____
__________________________	____
__________________________	____
__________________________	____

Are you allergic to any of the following?

Iodine	Yes	No	If yes, what happens? ____________________________________
IVP Dye	Yes	No	If yes, what happens? ____________________________________
Lidocaine	Yes	No	If yes, what happens? ____________________________________
Penicillin	Yes	No	If yes, what happens? ____________________________________

If you have any other problems or concerns that you would like us to know about, please explain below:

____
____
____
____
____