VeinologyNJ

Patient Name: _____ **Gender:** □ **Male** □ **Female**

Date of Birth: _____ **Social Security Number:** _____

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Marital Status: □ **Single** □ **Married** □ **Separated** □ **Divorced** □ **Widow**

Race:

□ **American Indian or Alaska Native** □ **Asian** □ **Black or African American**
□ **Hispanic or Latino** □ **Native Hawaiian or Other Pacific Islander** □ **White**
□ **Decline to Specify**

Preferred Language: □ **English** □ **Spanish** □ **Polish** □ **Italian** **Other:** _____

Emergency Contact: Name / Phone Number: _____

Access to patient portal: □ **Yes** □ No **(selecting yes will enable you to access your medical summary notes)**

Email address: _____

Occupation: _____ **Employer:** _____

Business Address: _____

Primary Insurance Company: _____ **Referral Required:** □ **Yes** □ No

ID#:_____ **Group Number:** _____

Secondary Insurance Company: _____

ID#: _____**Group Number:** _____

Pharmacy Information: _____

Name of Insured if other than you: _____

Relationship: _____ **Date of Birth:** _____

Occupation: _____ **Employer:** _____

Business Address: _____

Patient Signature: _____**Date:** _____

37 W. Century Rd Suite 104 • Paramus, NJ 07652 • Phone: (201) 546-5700 • Fax: (201) 297-6416
Website: www.veinolgynj.com

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Health History Form

Patient Name: _____ **Date of Birth:** _____

Name of Primary Care Physician: _____

Address: _____
Phone: _____ **Fax:** _____

Why are you here today?

_____

_____

How did you hear about VeinologyNJ ?

_____

Are you on any medications either prescribed or over the counter? List Below ☐ Yes ☐ No

_____

_____

_____

_____

Do you have any allergies to medication? ☐ Yes ☐ No
If yes, please list drug and reaction

Do you smoke tobacco? ☐ Yes ☐ No ☐ Quit **Packs per day for how many years?**_____

Do you consume alcohol? ☐ Yes ☐ No ☐ Quit **Drinks per week?** _____

Other drugs? _____

Have you had any past surgical procedures? ☐ Yes ☐ No
If yes, please list type and date

_____

_____

_____

_____

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Have you had any past hospitalizations? ☐ Yes ☐ No

If yes, please list reason and date

_____

_____

_____

Do you have any of the following conditions? (Please check all that apply and describe below)

☐	Diabetes	☐	Kidney Disease	☐	Chest Pain	☐	Arthritis
☐	Heart Disease	☐	Hepatitis	☐	Shortness of Breath	☐	High Blood Pressure
☐	Lung Disease	☐	Blood Clots	☐	Leg Pain	☐	Varicose Veins
☐	Stroke	☐	Bleeding Problems	☐	Swelling of Legs	☐	Leg Ulcers
☐	Stomach Ulcers	☐	High Cholesterol	☐	Spider Veins	☐	Other

_____

_____

_____

Family History. (Check all that apply)

		Father	Mother	Sibling	Other
☐	Blood Clots	☐	☐	☐	☐
☐	Bleeding Problems	☐	☐	☐	☐
☐	Leg Ulcers	☐	☐	☐	☐
☐	Varicose Veins	☐	☐	☐	☐
☐	Heart Disease	☐	☐	☐	☐
☐	Stroke	☐	☐	☐	☐
☐	High Blood Pressure	☐	☐	☐	☐
☐	High Cholesterol	☐	☐	☐	☐

Is there any other medical information that you would like to share?

_____

_____

_____

_____

_____

_____

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Venous Health History

1. Have you ever had ☐ vein stripping ☐ Ablation surgery ☐ Yes ☐No
   a. If yes, when and which leg? _____
2. Have you ever had vein injections? ☐ Yes ☐ No
   a. If yes, which leg and where on the leg? _____
3. Have you ever had a blood clot? ☐ Yes ☐ No
   a. If yes, which leg and when? _____
4. Have you ever had phlebitis? ☐ Yes ☐ No
   a. If yes, which leg and when? _____
5. Do you experience any of the following in your legs?

a. Aching/pain?	☐Right	☐Left	☐ Both	☐No
b. Heaviness?	☐Right	☐Left	☐ Both	☐No
c. Tiredness/fatigue?	☐Right	☐Left	☐ Both	☐No
d. Itching/burning?	☐Right	☐Left	☐Both	☐No
e. Swollen ankles?	☐Right	☐Left	☐Both	☐No
f. Leg cramps?	☐Right	☐Left	☐ Both	☐No
g. Restless legs?	☐Right	☐Left	☐ Both	☐No
h. Throbbing?	☐Right	☐Left	☐Both	☐No

   i. Other? _____

6. Have your veins gotten worse in recent months? ☐Yes ☐No
7. Do you take any medication for pain (i.e., Advil, Motrin) ☐Yes ☐No
8. Do you elevate your legs to relieve discomfort? ☐Yes ☐No
9. Do you exercise? ☐Yes ☐No
10. Do you wear compression stockings? ☐ Yes ☐No
    a. If yes, what type and gradient? How long have you worn them? _____
11. Do you have any problem walking? ☐ Yes ☐No
    a. If yes, how does it affect you? _____
12. What type of work do you do? _____
    a. How long do you stand (hours per day) at work? _____ At home? _____
13. Have you ever had any test(s) done on your veins? ☐Yes ☐No
    a. If yes, when and what type of test and where on the leg? _____
14. Were you diagnosed with saphenous vein reflux? ☐Yes ☐No

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ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign, transfer, and set over directly to **VeinologyNJ** sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic or elsewhere. I authorize NeuroSpine Plus LLC DBA /VeinologyNJ to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to NeuroSpine Plus LLC DBA /VeinologyNJ. I authorize NeuroSpine Plus LLC DBA /VeinologyNJ to release all medical information requested by my health insurance carrier, other physicians or providers, and any other third-party payers.

Print Name of Patient _____

Signature of Patient or Guardian_____ Date _____

VeinologyNJ

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). I understand that by signing this consent I authorize you to use and disclosure my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operation of your practice.

I have also been informed of and give the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Name of Patient _____

Signature of Patient or Guardian_____ Date _____

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You have the right:

- To considerate and respectful care consistent with sound nursing and medical practices
- To be informed of the name of the physician responsible for coordinating your care
- To obtain from the physician complete, current information concerning your diagnosis, treatment, and prognosis in terms I can reasonably be expected to understand
- To receive from the physician information necessary to give informed consent prior to the start of any procedure or treatment
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such action; You can still obtain alternative care.
- To privacy to the extent consistent with providing adequate medical care to you
- To privacy and confidentiality of all records pertaining to the your treatment, except as otherwise provided by law or third party payment contract, and to access to those records
- To review your medical records and if necessary have them explained to you
- To know what alternative care may be available to you
- To know what your treatment may cost

You have the responsibility:

- To provide all information about your past care, illness and medication to your physician
- To for being considerate to the needs of others in the office
- To provide all insurance information when requested, and following the requirements for your individual insurance plan for seeking treatment with the Doctor

Print Name of Patient _____

Signature of Patient or Guardian_____ Date _____

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Authorization For Release of Information

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

1. I hereby request and authorize VeinologyNJ to release information from the health record(s) of:

Patient's Name_____ Patient's Date of Birth_____

Patient's Social Security Number_____

I understand that this authorization includes permission to release information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV).

2. The requested information is to be sent to (name of doctor, hospital, person or organization where records should be sent):

Name: _____

Address: _____

Business Phone: _____ Fax: _____

3. The information to be released is and the records to be sent include (please provide dates of treatment and specific records):

_____

_____

4. Purpose/reason for release of records (circle): Insurance / Legal Matters / Marketing / Fundraising
Other (explain): _____

5. I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has already been made prior to receipt of the revocation.

6. I understand that my treatment is not conditioned on obtaining this authorization.

7. I understand that this authorization is specific for release only to the above party and expires (90) days following the date of signature.

8. I understand that information used or disclosed may no longer be protected by the federal privacy laws.

9. I understand that I can be charged for obtaining copies of my records according to the fee schedule established in the New Jersey Administrative Code.

10. If the requested information involves mental health information, I acknowledge that I am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed psychologist and that release of such information may waive this privilege.

11. I understand if this authorization is for marketing purposes that NJ Vein Care may receive direct or indirect compensation.

Print Name of Patient _____

Signature of Patient or Guardian_____ Date _____