The Vanishing Vein

Welcome!

REGISTRATION FORM

Section I: **Patient Information** **Date**_____

Name:_____
Address:_____ City:_____ State:_____ Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
The best number to contact me is: ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Whom may we thank for referring you? ☐ Primary Care Dr ☐ Web ☐ Friend/ Family ☐ Walk by ☐ Other

Primary Care Dr:_____ City:_____ Phone (_____)_____
Referring Physician: _____ City:_____ Phone (_____)_____

Person to contact in case of emergency_____Phone_____
Email Address_____
Would you like to receive our monthly aesthetic specials to be emailed to you? ☐ Yes ☐ No

Section II **Person Responsible For Bill If Different From Patient**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____
Guarantor Name:_____ Date of Birth:_____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer Name:_____ Work Phone (____)_____

Section III **Insurance Information **WE NEED A COPY OF YOUR CARD****

Primary Insurance Co._____
ID#_____ Group #_____
Ins Co Address:_____ Ins Co. Phone:_____

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

Secondary Insurance Co._____
Group #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:	Male or Female	**DOB:**

Past/Current Medical History

Have you had a Tetanus shot?	☐ Yes	☐ No	DATE:
Have you had a blood transfusion?	☐ Yes	☐ No	DATE:
Have you ever had a blood clot?	☐ Yes	☐ No	DATE:

Current Occupation:	

<u>Medical problems that other doctors have diagnosed.</u> Please be as specific as possible.

- ☐ Blood disorders/ Circulation:
- ☐ Cardiac (high blood pressure/ cholesterol/ diabetes):
- ☐ Intestinal, bowel, bladder:
- ☐ Skin:
- ☐ Ears, throat, nose:
- ☐ Lungs:
- ☐ Head/ neck:
- ☐ Muscle:
- ☐ Broken bones:

<u>Past Vein Care/ History.</u>

	Leg Addressed	Hospital/ Physician	Year
☐ EVLT procedure			
☐ Stripping/ phlebotomy/ ligation			
☐ Sclerotherapy			
☐ Vein Consultation BEFORE TODAY			
☐ Ultrasound of leg veins BEFORE TODAY			

<u>Surgeries & Other Hospitalizations.</u>

Reason	Hospital/ Physician	Year

Prescribed and over the counter (vitamins/ inhalers/ Advil) drugs taken regularly.		
Name of Drug	Strength	Frequency Taken

Allergies.			
Are you allergic to Latex?	☐ Yes	☐ No	Reaction:
Are you allergic to Adhesives?	☐ Yes	☐ No	Reaction:
Are you allergic to Lidocaine?	☐ Yes	☐ No	Reaction:

Medication Allergies:	Reaction:
Environmental:	Reaction:
Other (food, dogs, cats, etc):	Reaction:

WOMEN ONLY

Age at onset of menstruation?	
Date of last menstruation:	
Period every? # of days:	
Date of last pap and recent exam:	

Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies:	Number of Live births:	
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, Cesarean, or abortion?	☐ Yes	☐ No
Any problem with control of urination?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Are you sexually active?	☐ Yes	☐ No
If yes, are you trying for a pregnancy?	☐ Yes	☐ No
If not trying list contraceptive method used:	☐ Yes	☐ No

Social Medical History

Exercise:	☐ Sedentary (no exercise)			
	☐ Mild exercise (climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (work or recreation, less than 4x week for 30 min)			
	☐ Regular vigorous exercise (work or recreation 4x week for 30 minutes)			
Alcohol:	Do you drink alcohol?	☐ Yes	☐ No	
	How may drinks per week?			
Tobacco:	Do you use tobacco?	☐ Yes	☐ No	
	☐ Cigarettes	☐ Chew	☐ Pipe	☐ Cigars
	☐ # of years	☐ # pack/ day	☐ Or year quit	
Drugs:	Do you currently use recreational or street drugs?	☐ Yes	☐ No	
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No	

Family History

Family history of Varicose Veins?	☐ Yes	☐ No	Whom:
Family history of Blood Disorders?	☐ Yes	☐ No	Whom:
Family history of Blood Clots?	☐ Yes	☐ No	Whom:
Family history of pulmonary emboli?	☐ Yes	☐ No	Whom:

Any other significant FAMILY medical history?

Relation	**Significant Health Problem**

The Vanishing Vein
Dr. Brian Davison

61 Lincoln Street
Framingham, MA 01702
508-626-8346

Waiver/Assignment of Benefits

I authorize The Vanishing Vein of Framingham to submit to my insurance carrier for services that they believe to be "covered services" and to receive payment directly on my behalf. I authorize The Vanishing Vein to release financial and medical information, including photographs, to my insurance carrier for payment purpose only. I understand that I am financially responsible for and agree to pay for any services furnished to me by the Vanishing Vein of Framingham, which are not covered by my insurance carrier/carriers. I understand that I am financially responsible for and agree to pay any services furnished to me by The Vanishing Vein of Framingham, as a result of my failure to obtain the necessary referral and/or other authorizations from my primary care and/or referring physician when required.

Patient's Name- please print

Patient's Signature

Date of Service

Primary Care Physician