PENNSYLVANIA VASCULAR ASSOCIATES

SOCIETY HILL VEIN CENTER

PATIENT INFORMATION

NAME:____Date:____________

DATE OF BIRTH: _______________ AGE:_________ HEIGHT: ___________ WEIGHT: _________

@EMAIL ADDRESS:____

SOCIAL SECURITY #:____

ADDRESS:____

CITY:___________________________________ STATE:________ ZIP CODE:_______________

HOME PHONE #:____________________________ CELL #: ______________________________

PATIENTS EMPLOYER:_______________________WORK #:_______________________________

MARITAL STATUS: Single_____Married_____Widowed_____Seperated_____Divorced______

SPOUSE'S NAME:___________________________________ DATE OF BIRTH:________________

WHERE DID YOU HEAR ABOUT US?____

WHAT DOCTOR REFERRED YOU TO OUR PRACTICE:___________________________________

REFFERING DOCTOR ADDRESS:____

PHONE NUMBER #:_____________________________ FAX#:____________________________

PRIMARY DOCTOR:____

PRIMARY DOCTOR ADDRESS:____

PHONE NUMBER#:_____________________________ FAX#:____________________________

EMERGENCY CONTACT:____

RELATIONSHIP:_______________________________ PHONE #:_________________________

INSURANCE INFORMATION
(PLEASE PRINT)

NAME OF **PRIMARY** INSURANCE____

ADDRESS____

NAME OF SUBSCRIBER____________________ RELATIONSHIP TO SUBSCRIBER__________

POLICY NUMBER____________________ GROUP NUMBER__________

NAME OF **SECONDARY** INSURANCE____

ADDRESS____

NAME OF SUBSCRIBER____________________ RELATIONSHIP TO SUBSCRIBER__________

POLICY NUMBER____________________ GROUP NUMBER__________

FOR PATIENTS WITH MEDICARE COVERAGE PLEASE READ AND SIGN

I request payment of authorized Medicare benefits be made on my behalf to Pennsylvania Vascular Associates, P.C., or for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Agency and its agents any information nedded to determine the benefits payable for related services.

Signature____**Date**__________

I also request that payment of authorized Medigap benefits be made on my behalf to Pennsylvania Vascular Associates, P.C. for any services furnished me by that physician. I authorize any holder of medical information about me to release to my Medigap insurer any information nedded to determine these benefits payable for related services

Signature____**Date**__________

FOR PATIENTS WITH COMERCIAL/ANY OTHER INSURANCE PLEASE READ AND SIGN

To process my medical claims for payment I herby authorize Pennsylvania Vascular associated, P.C. or his authorized agents, to release copies of my medical records and/or provide information regarding my Physical or mental condition and treatment rendered to my insurance carrier and/or agent acting on the insurance carrier's behalf. I understand that these records and/or information may include psychiatric/psychotherapy, mental health, drug and/or alcohol information or treatment records, and I authorize the release of such records and/or information to my insurance carrier and/or agent acting on the insurance carrier's behalf.

I hereby assign Pennsylvania Vascular Associates, P.C. all payment for medical services rendered to myself and/or my dependents, and I understand and agree that any services not covered by my insurance company are my responsibility to pay.

Signature____**Date**__________

SOCIETY HILL VEIN CENTER

Date____________

Name____

Age__________ Male_____ Female_____ Blood Type___________________

Height_____________________ Weight_____________________ Shoe Size_________

Referred by____

PERSONAL MEDICAL HISTORY (CURRENT COMPLAINT) CHECK ALL THAT APPLY

1. Are you consulting for

    Cosmetic purposes _______

    Medical reasons _______

    Both _______

2. How many years have you noticed this problem? _______

3. Have you ever been treated for this problem by:

    Injection/Sclerotherapy _______

    Laser _______

    Surgery _______

4. Have you ever been treated for one of the following?

    Phlebitis (clotting of a vein) _______

        Right leg_______ Left leg_______

        Hospitalization? ______________

    Leg Ulcer _______

        Right leg_______ Left leg_______

        Date______________

Pulmonary Embolization (DVT) _______

Hospitalization? ______________

Leg Fracture _______

5. When did your veins occur?

Age________

Before Pregnancy________

During Pregnancy (which one)________

What are the ages of your children?_________________

After trauma____________

Other__________________

6. Are you developing new veins? Yes_______ No_______

7. Are your present veins getting bigger? Yes_______ No_______

8. Indicate which of the following problems you have experienced:

Pain in your	Right leg	Left leg
Lower limbs	_______	_______
Thigh	_______	_______
Calf	_______	_______
Leg	_______	_______
Foot	_______	_______
Swelling of the legs	_______	_______
Ulcer or Bleeding	_______	_______

9. If you experience pain in your lower limbs.

Is the pain exacerbated by:

Extended periods in standing position _______

Heat ________

Menstrual periods ________

Exercising and/or walking ________

Intercourse ________

Is the pain alleviated by:

Elevation of the limbs ________

Elastic stockings ________

Walking and/or exercising ________

Indicate the type of pain

Resting cramps ________

Night cramps ________

Tiredness ________

Heaviness in the legs ________

Pain in the specific areas ________

Numbness ________

Burning sensation ________

Additional comments:____

____

10. Do you have a family history of

Varicose veins ________

Blood clots/pulmonary embolism ________

Blood coagulation abnormality ________

11. Do you have a history of

Diabetes ________

High blood pressure _______

Seizures or convulsions _______

Fainting of dizziness _______

Stroke _______

Asthma _______

Hives _______

Arthritis _______

Autoimmune disease (e.g, Lupus) _______

Hepatitis _______

Bleeding disorders _______

Easy bruisability _______

Migraine headaches _______

Dark spots after pregnancy skin Injury or surgery _______

Do you have a personal history of allergies to medications? Please list drug and type or reaction.

____

____

____

Allergies to any foods _______

Allergies or sensitivity to adhesive tape _______

Have you ever had local anesthetic injection? _______

12. Does your work require a

Prolonged standing position _______

Prolonged sitting position _______

13. In the course of a normal day, how much time is spent in a standing position?

10% of the day_______ 50% of the day_______

20% of the day_______ More than 50%_______

14. Do you jog, run, jump rope of do aerobics at least weekly? _______

15. Are you pregnant or planning a pregnancy soon? _______

16. Do you smoke cigarettes? _______

If yes, how many packs per day? _______

17. Have you worn elastic support stockings? _______

18. List all medication (including aspirin)

____

____

____

19. List all previous surgeries

____

____

____

20. List all allergies

____

____

____

21.List all other medical problems

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