



### **Patient Information**

**Name:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Gender:**  Male  Female **Date of birth:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home phone:** ( \_\_\_\_\_ ) \_\_\_\_\_ **Work phone:** ( \_\_\_\_\_ ) \_\_\_\_\_

### **Insurance Information**

**Name of policyholder:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Patient relationship to policy holder:**  Self  Spouse  Parent/Guardian  Other

**Marital Status:**  Single  Married  Divorced  Separated  Widowed

### **Emergency Contact**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home phone:** ( \_\_\_\_\_ ) \_\_\_\_\_ **Work phone:** ( \_\_\_\_\_ ) \_\_\_\_\_

### **Financial Responsibility Agreement**

I/We hereby authorize Richmond Vein Center to furnish all information regarding my medical history, diagnosis and treatment of myself or my child to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We authorize payment of medical benefits to the Richmond Vein Center and further understand that should my account have to be referred to an attorney for collection that I am responsible for all fees and costs incurred therein. I/We hereby authorize Richmond Vein Center to act on my behalf in accessing hospital records when and if needed.

\_\_\_\_\_  
**Patient/Guardian Signature**

\_\_\_\_\_  
**Date**



**Photographic Image Consent and Release Form**

I hereby authorize Richmond Vein Center, P.C. to take photographic images of my legs and allow them to be used to help document and track the progress of my leg treatments, to be mailed to my Primary Care Physician and/or referring physician, and that they may be published in scientific journals and/or shown for scientific reasons.

I understand that these images will be the property of Richmond Vein Center, P.C. and that I will not receive any compensation (either financial or otherwise) in exchange for the use of these images. I understand that Richmond Vein Center, P.C. will remove all identifying information to the best of it's ability when the images will be seen by those who are not related to my care and medical treatment (i.e. anyone other than Richmond Vein Center Staff, other physicians, insurers or other parties involved with the treatment of my legs).

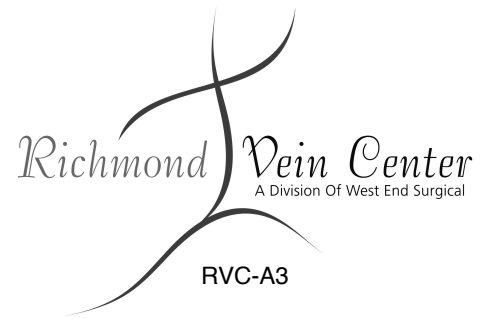
I have had the opportunity to ask questions about the purpose for which, and about the manner in which the images will be used, and all of my questions have been answered satisfactorily. I hereby release and hold harmless Richmond Vein Center, P.C., West End Surgical Inc. and their respective physicians, officers, employees and agents from liability for any claim I have, or might ever have, in connection with the use of these photographic images.

I understand that I may refuse to sign this Authorization. If I choose not to sign, my treatment will not be affected in any way. I also understand that I may revoke this Authorization at any time except to the extent that Richmond Vein Center, P.C. has already taken action in reliance on it. I may revoke the Authorization by written notification to Debra Gould at the Richmond Vein Center, P.C. or to whomever the current practice manager of the Richmond Vein Center, P.C. is.

Printed Name	Witness
Signature	Date

In addition to the above stated purposes authorized, I also hereby authorize Richmond Vein Center, P.C. to use these images for marketing and educational purposes. I understand that all of the same terms, conditions, and limitations will still apply as authorized above, and that by signing here I am allowing Richmond Vein Center, P.C. to use the images of my legs for additional purposes and not changing the agreement in any other way. I also understand that Richmond Vein Center, P.C. will make every effort to insure that all identifying information be removed when using these images for the purposes of marketing and education to the public.

Printed Name	Witness
Signature	Date



**Vein Treatment Question Sheet**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Gender:**  Male  Female **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Directions:** Please answer the following questions, trying not to leave any blanks.

**Past Medical History:**

1. Have you ever been in the hospital as a patient?  Yes  No  
- if yes, for what reason? \_\_\_\_\_
2. Have you ever had surgery?  Yes  No  
- if yes, what type of surgery and when? \_\_\_\_\_  
\_\_\_\_\_
3. Have you ever had vein stripping surgery?  Yes  No  
- if yes, when and which leg(s)? \_\_\_\_\_
4. Have you ever had vein injections (sclerotherapy)?  Yes  No  
- if yes, when, which leg(s) and where on the leg? \_\_\_\_\_  
\_\_\_\_\_
5. Are you presently under the care of a physician?  Yes  No  
- if yes, for what illness or purpose? \_\_\_\_\_
6. Do you have any of the following?  
- heart disease  Yes  No  
- lung disease  Yes  No  
- high blood pressure  Yes  No  
- hepatitis  Yes  No  
- arthritis  Yes  No  
- leg ulcer(s)  Yes  No
7. Have you ever had a blood clot?  Yes  No  
- if yes, which leg and when? \_\_\_\_\_
8. Have you ever had phlebitis (inflammation of a vein)?  Yes  No

**Child Rearing History:**

- 1. Do you think that you are presently pregnant?  Yes  No
- 2. How many times have you been pregnant?  Yes  No
- 3. Do you intend to have any more children?  Yes  No
- 4. Are you presently breast feeding?  Yes  No
- 5. Have you ever miscarried?  Yes  No

**Family History:**

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

- Father
- Mother
- Brother(s)
- Sister(s)
- Other \_\_\_\_\_

**Personal Vein History:**

- 1. Do experience any of the following?
  - Aching/pain in your legs  Yes  No
  - Heaviness  Yes  No
  - Tiredness/fatigue  Yes  No
  - Itching/burning  Yes  No
  - Swollen ankles  Yes  No
  - Leg cramps  Yes  No
  - Restless legs  Yes  No
  - Throbbing  Yes  No
  - Other: \_\_\_\_\_  Yes  No
- 2. Do you have any problems with walking?  Yes  No  
- if yes, how does it affect you? \_\_\_\_\_
- 3. Do you stand much at work?  Yes  No  
- at home?  Yes  No
- 4. How does this standing affect your legs? \_\_\_\_\_  
\_\_\_\_\_
- 5. Do you smoke?  Yes  No  
- if yes, how many packs per day? \_\_\_\_\_

6. Have you ever had your veins evaluated before?  Yes  No  
- if so, when and where? \_\_\_\_\_

7. Have you ever had any test(s) done on your veins?  Yes  No

**Current Medical History:**

1. Do you have any allergies (medicines, food, pollen, etc.)?  Yes  No  
- if yes, please list them and describe your reaction? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. Are you allergic to shrimp, shellfish or any form of iodine, IVP dye?  Yes  No

3. Are you presently taking any medication(s) including prescription and/or non-prescription (over-the-counter) medicines (aspirin, vitamins)?  Yes  No  
- Please list them: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. Do you take blood thinning medications?  Yes  No  
- if yes, Please list name(s)? \_\_\_\_\_

5. Are you taking hormones or birth control pills?  Yes  No  
- if yes, Please list name(s)? \_\_\_\_\_