TALLAHASSEE VEIN & FACE CLINIC

NEW PATIENT QUESTIONNAIRE

Patient Name: _____
Last Name First Name MI

PATIENT DEMOGRAPHICS

Gender: □ Male □ Female **Marital Status**: □ Single □ Married □ Divorced □ Widowed

DOB: _____ /_____ /_____ **SSN**: _____ - ____ - _____

Address: _____
Mailing Address City State Zip

Mobile Phone No: (_____) _____ - _____ **Home Phone No**: (_____) _____ - _____

Work Phone No: (_____) _____ - _____ **Email Address**: _____

Primary Insurance Company: _____

Name of Policy Holder: _____

Member ID: _____ Group No: _____

Secondary Insurance Company: _____

Name of Policy Holder: _____

Member ID: _____ Group No: _____

Primary Care Physician: _____

How did you hear about our practice? _____

DIGITAL RECORDING: Digital records by handheld devices such as smartphones are prohibited on the premises in order to protect the privacy of other patients and staff in compliance with federal and state privacy laws.

FINANCIAL RESPONSIBILITY: All professional services are charged to the patient and are due at the time of services, unless other arrangements have been made in advance with the office manager. Necessary forms will be completed to help expedite insurance carrier payments. However, you are responsible for all fees, regardless of insurance coverage. I have requested medical services from Tallahassee Vein & Face Clinic on behalf of myself and/or my dependents and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of appropriate statement.

ASSIGNMENT OF BENEFITS: I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Tallahassee Vein & Face Clinic for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize Tallahassee Vein & Face Clinic to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in course of examination or treatment and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Guardian Signature **Date**

COMMUNICATION PREFERENCE

Our office will reach out to remind you of your upcoming appointments. We are happy to be able to provide phone, text, and/or email reminders prior to your appointments. Please check your preferences below as well as providing the phone number and/or email address. For any of the below options, you will be asked to confirm or cancel.

□ Automated phone call reminder to (_____) _____ - _____
□ Text reminder to (_____) _____ - _____
□ Email reminder to _____

Emergency Contact: _____
Relationship: □ Spouse □ Parent □ Child □ Friend
Phone No: (_____) _____ - _____ **Alternate Phone No**: (_____) _____ - _____

HIPAA

Release of Information

□ My information is not to be released to anyone.
□ I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Receipt of HIPAA Privacy Notice

At Tallahassee Vein & Face Clinic, we are committed to maintaining the integrity of your protected health information as we comply with all applicable state and federal regulations. The federal privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) have taken effect as of April 14, 2003. In support of our policy of complying with all applicable regulations, we provide patients with the HIPAA Notice of Privacy Rights. While not required in order to receive treatment at this facility, we are obligated under federal regulations to ask that you sign an acknowledgment of the HIPAA Privacy Notice being made available to you.

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how my healthcare provider may use and disclose my protected health information. I understand that my healthcare provider reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____ _____

Patient/Guardian Signature **Date**

MEDICAL HISTORY

SURGICAL HISTORY

□ I have had no prior surgery.

Date	**Operation**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL CONDITIONS (Please check conditions you currently have or have had in the past)

□ **No current conditions**

□ Blood Clotting Disorder
□ Cardiac Stent
□ Diabetes Type _____
□ Dialysis Shunt
□ Epilepsy/Seizures
□ Fibromyalgia
□ Heart Attack
□ Heart Disease
□ Hemophilia
□ Hepatitis _____
□ HIV Positive
□ Keloid Scars
□ Kidney Disease
□ Latex Allergy
□ Lidocaine Allergy
□ Lower Back Pain
□ Migraines
□ Pacemaker
□ Rosacea
□ Shingles
□ Sickle Cell
□ Sleep Apnea
□ Spider/Varicose Veins
□ Stroke
□ Family history of vein disease

PHYSICAL ACTIVITY

On average, how many days per week do you exercise for at least 20 minutes continuously?

□ 1-2 □ 3-4 □ 5 or more □ I do not exercise this much

SOCIAL HISTORY

Substance	**Never**	**Previous** (year quit)	**Current** (please circle type/frequency)
Tobacco/Nicotine	□	□ _____	□ cigarettes, cigars, vape/e-cigarette, chew/dip/snuff
Alcohol	□	□ _____	□ _____ drinks per week/month

ALLERGIES

□ I have no known medication allergies.

Name of Medication	**Reaction**
_____	□ Anaphylactic shock □ Rash □ Itchiness □ Vomiting □_____
_____	□ Anaphylactic shock □ Rash □ Itchiness □ Vomiting □_____
_____	□ Anaphylactic shock □ Rash □ Itchiness □ Vomiting □_____
_____	□ Anaphylactic shock □ Rash □ Itchiness □ Vomiting □_____

MEDICATIONS (Please include over-the-counter medications and vitamins/supplements.)

□ I am not currently on any medication or vitamins/supplements.

Name of Medication	**Dosage**	**Directions**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____