

**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

VEIN QUESTIONNAIRE

- 1) Have you ever had vein stripping surgery?
 no yes (if so, which leg and when) _____
- 2) Have you ever had vein injections?
 no yes (if so, which leg and when) _____
- 3) Have you ever had a blood clot?
 no yes (if so, when) _____
- 4) Have you ever had painful, inflamed veins (phlebitis)?
 no yes
- 5) Do you experience any of the following in your legs?

	Right Leg	Left Leg
Aching/Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heaviness	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness/Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Itching/Burning	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Restless Legs	<input type="checkbox"/>	<input type="checkbox"/>
Throbbing	<input type="checkbox"/>	<input type="checkbox"/>
- 6) Have your leg symptoms gotten worse recently?
 no yes (if so, please explain how) _____
- 7) Do you take medication for pain?
 no OTC medication (Tylenol, Motrin, Aleve) Other _____
- 8) Do you prop up your legs to relieve discomfort?
 no yes (if so, how often?) _____
Does propping up your legs relieve your symptoms? no yes
- 9) Do you exercise?
 no yes
- 10) Have you been diagnosed with venous disease?
 no yes
- 11) Are you being treated for leg problems or for problem veins?
 no yes (if so, who is treating the leg/veins) _____