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## PATIENT INFORMATION

Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Home Address: _____ City: _____ State_____ ZIP: _____

Social Security #: _____ Marital Status: Single Married Divorced Widowed

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

How did you hear about us?: _____

HIPPA Choices:

Did you receive a copy of the HIPAA notice? YES _____ NO _____ Allow Voice Msg? YES _____ NO _____

Allow SMS (text message)? YES _____ NO _____ Allow postal mail? YES _____ NO _____

Occupation: _____ Employer: _____

Language: _____ Race/Ethnicity: _____

Primary Health Insurance Name: _____ ID#: _____

Group #: _____ Subscriber: Self _____ Spouse _____ Other _____

Subscriber's Name: _____ DOB: _____

Secondary Health Insurance Name: _____ ID#: _____

Group #: _____ Subscriber: Self _____ Spouse _____ Other _____

Subscriber's Name: _____ DOB: _____

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Patient Name: _____

Height: _____'_____" Weight: _____ Gender: Male Female

Reason for Visit: _____

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Chief Complaint:

____Aching
____Awakened at night
____Bleeding from veins
____Burning
____Cramping
____Diff. healing wounds
____Fatigue
____Heaviness
____Itching
____Pain
____Restless legs
____Swelling
____Ulcers
____Varicose veins
____Spider veins
____Skin discoloration
Other: _____
_____

Which Leg: Right Left Both How long: _____

Ulcer on Leg: No Yes: which leg? _____ for how long? _____

Timing of Symptoms: ____Intermittently ____Mostly at night ____Only during daytime

____All day ____While laying down ____Bedtime ____Other: _____

How do these symptoms affect your activities of daily living?

Work: _____
Daily Chores: _____
Care for Family: _____
Travel: _____
Walking/Exercising: _____
Other: _____

Symptoms made worse by:
____Walking ____Exercise ____Prolonged Standing ____Prolonged Sitting ____Leg Elevation ____Heat
____Premenstrual ____Pregnancy ____Travel ____Other: _____

Symptoms made better by:
____Resting: how often? _____ ____Leg Elevation ____Standing ____Sitting
____Walking ____Exercise ____ Heat ____Other: _____

Conservative Therapy: (please check any of the conservative therapy measures you have tried)
____Compression Stockings ____Elevation ____Weight Reduction ____Exercise
____Avoiding Prolonged Sitting/Standing ____Tylenol/Motrin ____Other: _____

How long have you been using conservative measures? _____

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**Vein History**
**Past Vein Procedures:**

_____

_____

**Past Vein History:** ____DVT ____PAD ____Leg Ulcers Other: _____

**Are you on any blood thinners?** YES NO If yes, what? _____

**Past Medical History:**
____CAD ____High Cholesterol ____High Blood Pressure ____Gout ____Diabetes ____CHF
____HIV/AIDs ____Hepatitis ____Mental Health Disorder ____Neuropathy (Peripheral) ____Heart Defect
____Hypothyroidism ____Peripheral Vascular Disease Other: _____

**Past Surgeries:**

_____

_____

_____

**Family History:**____Venous Disease ____Clotting Disorder ____Stroke
____Diabetes ____Hypertension ____Cancer Other: _____

**Social History:** Alcohol: ____Never ____Rare ____Occasional ____Daily
Smoking: ____Never ____Current Smoker
____Quit >1 year ____Quit 1-10 years ____Quit 10+ years

**Female History:** ____#pregnancies ____planning for pregnancy

**Allergies:**

_____

_____

_____

**Current Medications:**

_____

_____

_____

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**Review of Systems:** **(please check all that apply)**

Constitutional:
____ Fatigue
____ Fever
____Recent weight loss
____Recent weight gain

Cardiovascular:
____Chest pain
____Palpitations
____Shortness of Breath
____with walking
____while lying flat
____Swelling legs/ankles
____Varicose veins

Respiratory:
____Chronic/Freq cough
____Cough/spit up blood
____Wheezing
____Asthma

Gastrointestinal:
____Abdominal Pain
____Black tarry stools
____Changes in bowel habits
____Difficulty/Pain swallowing
____Heartburn
____Hemorrhoids
____Indigestion
____Jaundice
____Pain on defecation
____Rectal bleeding
____Vomiting of blood

Genitourinary:
____ Blood in urine
____ Difficulty urinating
____Irregular/abnormal periods
____Pain or burning with urination
____Pain with intercourse
____Pain with menstruation
____Pelvic pain
____Vulvar veins

Musculoskeletal:
____Ankle pain
____Back pain
____Foot pain
____Hip pain
____Knee pain
____Leg cramps

Integumentary:
____Easy skin bruising
____Eczema
____Hair loss
____Heavy sweating
____Itching
____Rashes
____Skin lesions
____Ulcers

Endocrine:
____Cold intolerance
____Excessive thirst
____Excessive urination
____Heatintolerance
____Incontinence

Hematologic/Lymphatic:
____Bleeding tendencies
____Enlarged lymph nodes

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## ASSIGNMENT OF BENEFITS FORM

I, _____, understand that services rendered to me by O'Donnell Vein and Laser/Kelly O'Donnell, M.D. are my financial responsibility and that the provider will bill my insurance company. I authorize my insurance company to pay my benefit directly to O'Donnell Vein and Laser/Kelly O'Donnell, M.D. and I understand that I will be responsible for any amount allowed and not paid by my insurance company. I am also responsible for any Deductible, Copay and/or Co-insurance.

I authorize the provider to release any information necessary to adjudicate my claims.

I also understand that should my insurance company send payment directly to me, I will forward the payment to the office in a timely manner.

I certify that the information I have provided with regard to my insurance coverage is current and correct. I agree to continually provide current and accurate health insurance information should any changes occur. I agree to notify the office of any updated insurance information prior to any services being rendered.

I authorize O'Donnell Vein and Laser/Kelly O'Donnell, M.D. to initiate a complaint or file an appeal to my insurance company and/or the insurance commissioner on my behalf and I personally will be active in the resolution of any claim delays, unjustified reductions or denials.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

## COLLECTION AGREEMENT

If payment is not made as agreed, I will be responsible for all court costs, 35% collection fees and attorney fees.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

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# Optional Cosmetic Interest Form

Please select any skin concerns you are interested in learning more about:

- ☐ Fine Lines/Wrinkles
- ☐ Sun Damage (Hands/Arms)
- ☐ Brown Spots/Pigmentation
- ☐ Red Spots/Facial Veins
- ☐ Uneven Skin Tone
- ☐ Unwanted Facial/Body Hair
- ☐ Spider Veins
- ☐ Scars
- ☐ Double Chin
- ☐ Acne
- ☐ Flat Cheeks/Mid-face Volume Loss
- ☐ Lips: Shape/Fullness
- ☐ Skin Texture
- ☐ Large Pores
- ☐ Loose Skin
- ☐ Permanent Fat Reduction/ Body Contouring

Share with us any other areas of concerns:

_____

_____

_____

_____

_____

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