THE INSTITUTE FOR
VEIN HEALTH

# Patient Registration Form

**First Name:**_____

**Last Name:** _____

**Email:** _____

**Home Phone:** _____ **Cell Phone:** _____

☐ I would like to receive news and promotions from The Institute for Vein Health

**Date of Birth**_____-_____-_____ **Gender:** Male Female

**Marital Status (circle one):** Married Single Widow/Widower

**Address:** _____

**City State and Zip Code:** _____

**Emergency Contact Name:** _____

**Emergency Contact Phone Number:** _____

**How did you hear about us (circle one)?** Google Website Facebook Other _____

Referred by a friend (name) _____ Referred by a doctor (name) _____

## Notice of Privacy Practices (HIPPA)

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). You have certain right under this law and we are dedicated to protecting your rights, to learn more visit http://www.hfs.illinois.gov//hippa/

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. W also are required by law to provide you with this notice acknowledging our legal duties concerning your protected health information.

**Please Initial here** _____ that you have read our HIPPA law explanation.

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# Insurance Information

**Name of Primary Insurance Company:** _____

If this insurance is not in your name please fill out the following:

**Name of Policy Holder:** _____

**Date of Birth of Policy Holder:** _____ **Relationship to Policy Holder:** _____

**Secondary Insurance Company:** _____

If this insurance is not in your name please fill out the following:

**Name of Policy Holder:** _____

**Date of Birth of Policy Holder:** _____ **Relationship to Policy Holder:** _____

**Self-pay:** ☐

**Authorization:** I authorize the release of medical information necessary to process this claim or provide medical information to my insurance carriers, or to any physician or medical facility. I authorize payment of medical benefits to Dr. Brukasz and The Institute for Vein Health for all Professional goods and services rendered. I understand I am financially responsible for any charges whether or not covered by Insurance.

**Signature:** _____ **Date:** _____

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Please tell us what you do for work. If you are retired what did you do before you retired:

_____

Please describe any problems or issues with your legs that has brought you into our office today:

_____

_____

Do you have a primary doctor or family doctor that you currently see: ☐ YES ☐ NO

If so can you please provide us with your doctors' name and phone number, otherwise please put none:

_____

May we send a report of our findings and recommendation to your doctor? ☐ YES ☐ NO

Please list all medications and supplements that you are currently taking: _____

_____

_____

Do you have any allergies? _____

_____

Have you ever had any surgeries or been hospitalized in the past? _____

_____

_____

## Family History

**Has anyone in your family had any of the following issues or conditions. Please circle Yes or No.**

| | | | | | |
|---|---|---|---|---|---|
| Varicose Veins | YES | NO | Phlebitis | YES | NO |
| Spider Veins | YES | NO | Vein Stripping | YES | NO |
| DVT or Deep Vein Thrombosis | YES | NO | Blood Clots | YES | NO |
| Venous Ulcers | YES | NO | Vein Treatments | YES | NO |

Name: _____ Date: _____

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Have you personally had any of the following:

**Please Circle Which Leg and List When**

| | | | | |
|---|---|---|---|---|
| Vein Stripping: | Left | Right | Neither | If so when: _____ |
| Laser Vein Treatment: | Left | Right | Neither | If so when: _____ |
| Sclerotherapy: | Left | Right | Neither | If so when: _____ |
| Hemorrhage from a varicose vein: | Left | Right | Neither | If so when: _____ |
| Phlebitis: | Left | Right | Neither | If so when: _____ |
| A DVT or deep vein thrombosis or blood clot: | Left | Right | Neither | If so when: _____ |
| Surgery or any broken bones in your leg: | Left | Right | Neither | If so when: _____ |

| | | |
|---|---|---|
| Have you ever worn compression stockings to help your vein problems: | YES | NO |
| Have you ever taken pain medicine due to you vein problems: | YES | NO |
| Have you had to take time off work due to your vein problems: | YES | NO |
| Have you had to limit your activities due to your vein problems: | YES | NO |

**Please circle if you are currently on or have been on the following medications:**

Coumadin Plavix Daily Aspirin Steroids Antibiotics Skin Ointments

If so when and for what diagnosis: _____

**Please Circle if you have any of the following medical conditions:**

| | |
|---|---|
| Cancer | Seizures |
| Arthritis | Kidney Failure |
| Hypertension | Fainting |
| Lung Disease | Hepatitis |
| Heart Disease | HIV/AIDS |
| Diabetes | Tobacco If yes how much_____ |

Name: _____ Date: _____

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**Do you have any of the following (Please circle YES or NO and which symptom):**

| | | |
|---|---|---|
| Fevers, chills loss of weight or apatite | YES | NO |
| Change in vision, double vision or excessive tearing | YES | NO |
| Changes in hearing, sore throat, dizziness or ringing in the ears | YES | NO |
| Chest pain, chest tightness, new heart medication or shortness of breath | YES | NO |
| Cough, pain with breathing, difficulty breathing, emphysema or coughing blood | YES | NO |
| Vomiting, belly pain, black, red or bloody stool | YES | NO |
| Urinary incontinence, frequent, urgent or painful urination | YES | NO |
| Pain while walking or moving. Painful joints | YES | NO |
| Problems with rashes, itching, skin discoloration or sores that don't heal | YES | NO |
| Numbness in the arms, legs or elsewhere. Tingling or loss of memory | YES | NO |
| Any suicidal thoughts or hallucinations | YES | NO |

**This Section for Women Only:**

| | | |
|---|---|---|
| Are you pregnant or think you might be: | YES | NO |
| Are you currently breast feeding: | YES | NO |
| Will you have more children in the future: | YES | NO |
| Are you taking oral contraceptives: | YES | NO |
| Are you on HRT or hormone replacement therapy: | YES | NO |

How many times have you gone through childbirth: _____

Name: _____ Date: _____