



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

Name _____ Date _____



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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: _____

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: _____

Name _____ Date _____



THE INSTITUTE FOR VEIN HEALTH

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

Did you ever use Tobacco? NO YES Do you use Tobacco? NO 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 _____