

THE VEIN CENTER

TODAY'S DATE: _____

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____

SEX: M F DOB: _____ AGE NOW: _____ SSN: _____ / _____ / _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PLACE OF EMPLOYMENT: _____ WORK PHONE: _____

CIVIL STATUS: MARRIED DIVORCED SINGLE WIDOWED OTHER

SPOUSE'S NAME: _____ IF MINOR, PARENT/GUARDIAN NAME: _____

INSURANCE INFORMATION:

MEDICAREPOLICY# _____ MEDICAIDPOLICY# _____

INSURANCE COMPANY NAME: _____ POLICY# _____ GROUP# _____

INSURANCE COMPANY NAME: _____ POLICY# _____ GROUP# _____

CARDHOLDER INFORMATION

LAST NAME: _____ FIRST NAME: _____ M.I. _____

RELATIONSHIP: _____ DOB: _____ SSN: _____ / _____ / _____ SEX: M F

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PLACE OF EMPLOYMENT: _____

IN CASE OF EMERGENCY NOTIFY: (OTHER THAN SPOUSEII)

NAME: _____ PHONE# _____

ADDRESS: _____ RELATIONSHIP: _____

NAME: _____ PHONE# _____

ADDRESS: _____ RELATIONSHIP: _____

ALLERGIES TO MEDICATIONS:

REQUIRED INFORMATION ON NEXT PAGE

MEDICAL HISTORY - REQUIRED

LIST ALL CURRENT MEDICATIONS, INCLUDING DOSAGE, STRENGTH, ETC.

- 1 _____ 8 _____
- 2 _____ 9 _____
- 3 _____ 10 _____
- 4 _____ 11 _____
- 5 _____ 12 _____
- 6 _____ 13 _____
- 7 _____ 14 _____

DO YOU: SMOKE? YES NO HOW MUCH DAILY? _____
 DRINK COFFEE? YES NO HOW MUCH DAILY? _____
 DRINK ALCOHOL? YES NO HOW MUCH? _____
 TAKE DIET MEDICATION? YES NO FOR HOW LONG? _____

<u>IMMUNIZATIONS:</u>	<u>DATE:</u>	<u>DIAGNOSTIC PROCEDURES</u>	<u>DATE</u>
PNEUMONIA	_____	PAP SMEAR	_____
FLU VACCINE	_____	MAMMOGRAM	_____
TETANUS	_____	PROSTATE	_____
TB	_____	COLONOSCOPY	_____
		LAST COMPLETE PHYSICAL	_____

(IF CHILD, NEED COPY OF IMMUNIZATION RECORD)

LIST HOSPITALIZATIONS AND SURGERIES:

- 1. _____ DATE: _____ PHYSICIAN: _____
- 2. _____ DATE: _____ PHYSICIAN: _____
- 3. _____ DATE: _____ PHYSICIAN: _____
- 4. _____ DATE: _____ PHYSICIAN: _____
- 5. _____ DATE: _____ PHYSICIAN: _____

HEART DISEASE? YES NO BLEEDING DISORDER? YES NO
 HIGH BLOOD PRESSURE? YES NO KIDNEY DISEASE? YES NO
 CANCER? YES NO THYROID DISEASE? YES NO
 DIABETES? YES NO OSTEOPOROSIS? YES NO
 STROKE? YES NO ASTHMA? YES NO
 OTHER DISORDERS? YES NO IF YES, PLEASE EXPLAIN: _____

FAMILY HEALTH HISTORY

- A. FATHER: IF LIVING, GIVE AGE _____ HEALTH PROBLEMS? _____
 IF DECEASED, AGE AT TIME OF DEATH _____ CAUSE? _____
- B. MOTHER: IF LIVING, GIVE AGE _____ HEALTH PROBLEMS? _____
 IF DECEASED, AGE AT TIME OF DEATH _____ CAUSE? _____
- C. BROTHERS AND SISTERS: TOTAL _____ NUMBER LIVING? _____ NUMBER DECEASED? _____
 CAUSE? _____ OTHER HEALTH PROBLEMS? _____
- D. CHILDREN: TOTAL _____ AGES: _____ ILLNESSES? _____

The Vein Center
2501 South Willis, Suite D
Abilene, Texas 79605
(325) 668-8046

I hereby accept all medical treatment at The Vein Center, Abilene, Texas, as provided by the medical staff. I will read and follow all pre and post procedure instructions provided to me.

The Vein Center may disclose all or any part of the patient's records to any person(s) or company liable for all or part of the centers charges, included but not limited to Family Physician and Insurance companies.

It is further understood that The Vein Center will accept Medicare assignment. In the event the undersigned is entitled to benefits of any type, arising out of any insurance, insuring the patient or any other party liable to the patient, said benefits are hereby assigned to The Vein Center for application on the patient's bill. It is agreed that The Vein Clinic will accept such receipt for any such payment towards the charges. The undersigned, and/or patient, is responsible for charges not covered or addressed by this assignment.

The undersigned certifies that he/she has read the foregoing, and is the patient, or is duly authorized by the patient as the patient's guardian to execute the above and accept its terms.

DATE

PATIENT

WITNESS

PATIENT SIGNATURE

Relationship To Patient

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority