PATIENT REGISTRATION

(Please Print)

Patient Name: ____ Age: __________

Date of Birth: ________________________ Social Security Number: ________________

Address: ____

City, State, Zip: ______________________________________ Phone: (   ) __________

Please Choose One: Cell: (   ) __________

Male: ❒ Female: ❒ Marital Status: Married: ❒ Divorced: ❒ Single: ❒ Widow: ❒

Occupation: ______________________________ Employer: _____________________

Employer Address: ____

City, State, Zip: ______________________________________ Phone: (   ) __________

Name of Spouse: ________________________________ Occupation: ___________________

Spouse's Employer: ____ Phone: (   ) __________

Nearest Relative / Friend: ____________________________________ Phone: (   ) __________

If a physician referred you, please note his/her name, phone number and address:

Referring Physician Name: __________________________________ Phone: (   ) __________

Address, City, State, Zip: ____

If a friend referred you, please provide his/her name: _________________________________

Family Physician / Gynecologist: _____________________________ Phone: (   ) __________

INSURANCE INFORMATION

(Please provide a card so we may copy it for our records. Thank you!)

First Carrier: ____

Insured's Name: ___________________________ Insured's DOB: _________________

Group Name and/or #: ______________________ ID#: ______________________________

Second Carrier: ____

Insured's Name: ___________________________ Insured's DOB: _________________

Group Name and/or #: ______________________ ID#: ______________________________

I hereby request and authorize direct payment of benefits specified under my policy to be paid to the corporations named below. Further, I hereby authorize endorsement of any check(s) made payable to the below named. I understand and agree I am financially responsible for any unpaid balances not covered by this agreement.

I also authorize the release of any medical information by the above providers to any applicable insurance carriers or self-funded employers as may be required to facilitate payment of benefits.

❒ Iowa Vein Center ❒ Westown Ambulatory Center

____________________________ Date: __________ ____________________________ Date: __________

Insured's Signature Insured's Signature

(For internal use only – Initial & Date) ❒ Info given regarding quality of care ____

PAST MEDICAL HISTORY

Patient Name: ________________________ Weight: ________ Height: ________
Describe chief complaint: *(reason for seeking medical attention)* _______________________
____
____

SOCIAL HISTORY: Ethnicity (Circle one): Hispanic/Latino Non-Hispanic/Non-Latino
Primary Language: _____________ **Special Language Spoken/Translate** ______________

Race (Circle one): Caucasian African American Asian Hispanic Other _____________

Number of Pregnancies: ________ Number of Children: _______

Are You Pregnant Now: N Y Unsure Are you Nursing: N Y

Alcohol use: N Y # per day ____ # per wk. ____ Current Smoker: N Y

Packs per day: ____ Have you ever smoked N Y If Yes year you quit_______

Exercise: N Y How often: _______ per wk How long: _______ Type ____________

PAST PERSONAL HISTORY:	**YES**	**NO**
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Diabetes	☐	☐
Gout	☐	☐
Overweight	☐	☐
Jaundice (Hepatitis)	☐	☐
Bronchial Asthma	☐	☐
Migraine Attacks	☐	☐
Tuberculosis (TB)	☐	☐

HOSPITALIZATIONS/ILLNESS/
For surgical reasons, (list procedures and at what age)
____

____
CHRONIC MEDICAL CONDITIONS:
____

____

Patient’s Name: ________________________ Date: _____________

ALL MEDICATIONS CURRENTLY BEING TAKEN:

Please be sure to write in dose and frequency **(please list. Continue on back side if needed)**

Prescription Medication	Dose	Frequency	Updates
Over-the-Counter			
Vitamins/Herbs			

PHARMACY:

NAME: ___________________________ **PHONE:** ___________________________

ADDRESS: ____

Rev. 04/13

Patient Name: ______________________ **Date:** __________

ARE YOU CURRENTLY ON:	**YES**	**NO**
Oral Contraceptives/Premarin	______	______
Aspirin	______	______
Steroids Anticoagulant	______	______
Digoxin	______	______

Do you take Antibiotics before you go to the dentist? **YES** **NO**

ALLERGIES/SENSITIVITIES: Do you have any history of skin reactions (rash, hives) or any reactions or sickness from taking any drugs or ingestion of foods? **YES** **NO**

If yes, please list: ____

ARE YOU ALLERGIC TO:		
Iodine	______	______
Local Anesthetics (Xylocaine)	______	______
Tape, Adhesives	______	______
Latex	______	______

FAMILY HISTORY

MEMBERS OF THE FAMILY WITH VARICOSE VEINS

Mother ______

Father ______

Grandparents ______

Brother ______

Sister ______

Family history of clots or phlebitis ______

Family history of clots in the lungs or pulmonary embolism ______

Family history of death due to complications of vein problems ______

Family history of diabetes ______

Family history of cardiovascular problems ______

PERSONAL FACTORS & PREVIOUS TREATMENT

Are you exposed to the sun? _______

Do you use a jacuzzis or hot tubs? _______

Do you try to avoid the use of heels? _______

Do you try to avoid obstructive garments such as tight pants, belts or any type of tight clothing? _______

Do you try to avoid prolonged periods of sitting and/or standing? _______

Do you carry heavy loads? _______

Do you walk regularly? _______

Do you elevate your affected leg occasionally? _______

Are you trying to lose weight? _______

Have you noticed occasional swelling of your ankles? _______

Do you take occasional over the counter analgesics for leg discomfort? _______

Have you had any treatments? _______

Have you worn any type of compression stockings or elastic bandages? _______

When did your varicose veins appear for the first time?

During or after pregnancy _______

After an injury _______

After taking birth control pills _______

Do you have any bleeding disorders? i.e. Factor V Leiden _______

PREVIOUS HISTORY OF	Yes	No	Right	Left
Superficial Phlebitis or Clots	______	______	_______	_______
Deep Vein Phlebitis or Clots	______	______	_______	_______
Lung Clots	______	______	_______	_______

HAVE YOU HAD ANY DEGREE OF DISABILITY Y N

If Yes please explain: ____

RISK FACTORS

Have you every had sclerotherapy? __________ If so, which leg & when? ________________________

Have had varicose vein surgery? __________ If so, which leg & when? _________________________

Have you ever had a leg ulcer? __________ If so, when & where? _________________________

Have you ever had arterial or heart problems? ____________

Do you have pain with walking? Y N

DO YOU HAVE or HAVE HAD

	Yes	No	Right	Left
Pain	______	______	______	______
Ankle and foot swelling	______	______	______	______
Itching	______	______	______	______
Night cramps	______	______	______	______
Bleeding from the veins	______	______	______	______
Pigmentation or brown skin color	______	______	______	______
Dermatitis or red skin color	______	______	______	_____
Thickness of the skin	______	______	______	______

WHAT MAKES THE PAIN WORSE?

Does the discomfort become worse by standing or sitting? ______

Are the symptoms worse during hot weather? ______

your period? ______

at night? ______

is it worse in the AM or PM? ______

worse when you are moving or not moving? ______

when did you start having problems? ______

SYMPTOMS

If you have pain in your legs due to varicose veins, a description of the pain may fit several of the words used below.

Circle any words that describe your discomfort.

cramping	burning	tingling
aching	heaviness	tender
tiredness	itching	numbness

Please help us in our efforts to provide the best service to our patients by answering the following questions:

1. What was your primary source of referral in choosing the Iowa Vein Center? (Choose one)

   __________ Referred by my physician

   __________ Recommended by friend or family member

   __________ Saw advertisement in Yellow pages

   __________ Read about service in the Iowa Vein Center brochure or other locations

   __________ Saw advertisements in newspaper

   ________ Des Moines Register

   ________ Other

   __________ Radio/Television

   __________ Billboard

Please explain ____

2. How long did you think about scheduling this procedure before making an appointment?

   __________ Same day   __________ 1-6 Months

   __________ Less than 1 week   __________ More than 6 months

   __________ Less then 1 month

3. When calling for an appointment, was the receptionist helpful and courteous in setting up an appointment for your convenience?

   __________ Yes   __________ No   If no, explain ____________________________________

   ____

4. Whose advise did you seek when considering this procedure?

   ________ Mother/Father   ________ Friend   _________ No one

   ________ Child   ________ Family Doctor   _________ Spouse

   ________ Brother/Sister   ________ Barber/Beautician   _________ Pharmacist

   ________ Other, please explain ____

5. Age: ________ Under 18   ________ 26-35   ________ 46-60

   ________ 18-25   ________ 36-45   ________ 60+

6. Occupation:

   _____ Management/Admin.   _____ Tradesperson   _____ Professional   _____ Blue Collar

   _____ Secretary/Clerical   _____ Volunteer   _____ Banking/Finance   _____ Household

IOWA VEIN CENTER
2425 Westown Parkway
West Des Moines, IA 50266

Dear Patient,

During your consultation, we MAY be performing some non-invasive tests on you. These tests may be a Doppler and/or Duplex Study of your leg(s). The charges for these tests will be submitted to your insurance company.

No tests will be performed unless the Iowa Vein Center Staff feels that they are absolutely necessary to properly diagnose and assess your condition and individually tailor the best treatment for you. The old fashioned visual assessment and diagnosis of venous problems (just looking at your veins) is inaccurate and misleading. Therefore this office has state-of-the-art equipment to give us a clear picture of any problem and the best way to treat it. More-over, these tests could differentiate between cosmetic and medical necessity of your problem. This in turn may facilitate your insurance carrier together with the extended consultation fee.

<u>YOU ARE RESPONSIBLE FOR ANY DEDUCTIBLE OR CO INSURANCE FOR THIS TEST.</u>

Should you have any questions about our policies, please do not hesitate to ask our staff.

I have read the above and I understand that I am responsible for paying my deductible and co insurance if it applies for these non-invasive diagnostic tests.

Signed ____ Date ______________

IOWA VEIN CENTER
2425 Westown Parkway, Ste 100
West Des Moines, Iowa 50266
(515) 222-8346

Directions to Iowa Vein Center

From I-235 West Bound

- Take 22nd Street Exit towards West Des Moines/Clive
- Turn right on 22nd Street
- Left on Westown Parkway (Walgreen's is on the corner)
- Next to Meineke

From I-235 East Bound

- Exit at 22nd Street, West Des Moines/Clive
- Turn left on 22nd Street
- Turn left on Westown Parkway (Walgreen's is on the corner)
- Next to Meineke on right hand side of road