CALCAGNO AND ROSSI VEIN TREATMENT CENTER
PATIENT INFORMATION SHEET

Last Name:_____ First Name:_____ Middle Initial:_____ Male:__Female:___

Is this your legal name? Yes / no If not, what is your legal name:_____

Address:_____City:_____State:_____Zip:_____

** PLEASE SPECIFY WITH A* ☑ *WHERE WE MAY LEAVE MESSAGES**

Home phone #:_____ Work phone #:_____Cell #:_____

Email Address:_____ How did you hear about us?_____
(for access to your patient portal)

☐ **Yes** ☐ **No**

Would you like to join our email list *(periodic brochures, newsletters, etc)***?**

Birthdate: _____Age:_____ SS Number:_____ Marital Status: S M W D

Employer Name/Address:_____

Spouse's Name_____ Spouse's Birthdate_____ Emergency Contact:_____ Phone number:_____

Family Physician:_____Phone:_____

Referring Physician:_____Phone:_____

Pharmacy:_____Phone:_____fax:_____

INSURANCE INFORMATION

Primary Ins Name_____Policy # _____Group#_____

Policy Owner_____Birthdate_____

Secondary Ins Name_____Policy #_____Group #_____

Policy Owner_____Birthdate_____

Other responsible party:

Name_____Relationship_____Birthdate_____

I request that payment of authorized medical benefits, including Medicare benefits, be made either to me or on my behalf to **Calcagno and Rossi Vein Treatment/Surgery Center LLC** for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents, my insurance company or its intermediaries or carriers, this physician's office, my attorney or other physician's offices any information needed to determine these benefits or the benefits payable for related services or as may be needed for my medical care. I permit a copy of this authorization to be used in place of the original. This agreement will remain in effect until revoked by me in writing.

Signature of Patient: **X**_____Date:_____

I request that payment for authorized **Medigap/Employer Supplemental** benefits be made either to me or on my behalf to **Calcagno & Rossi Vein Treatment Center LLC** for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release to_____information need to determine these benefits payable for related services.

Signature of Patient:_____Date:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information to:

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

I understand that this information is voluntary and that the recipient of this information is not a health plan or healthcare provider and that the released information may no longer be protected by federal privacy regulations. I understand that this authorization will not expire until I notify Calcagno and Rossi Vein Treatment Center LLC in writing.

The following information is for government reporting purposes only:

RACE:						
☐ African American -- Non-Hispanic	☐ American Indian / Alaskan Native	☐ Hispanic	☐ Asian/Pacific Islander	☐ White-Non-Hispanic	☐ Other	
ETHNICITY:						
☐ African American/Black	☐ American Indian	☐ Asian	☐ Hispanic	☐ Pacific Islander	☐ Caucasian/White	☐ Other
LANGUAGE:						
☐ English	☐ Spanish	☐ Japanese	☐ French	☐ other		

Do you have an Advanced Directive? O No O Yes **(if yes, please provide our office with a copy)**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OR PRIVACY POLICY

I hereby acknowledge that I have received the opportunity to review the Notice of Privacy Practices for protected health information for the Calcagno & Rossi Vein Treatment Center LLC: X_____.

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have questions about our fees, our financial policy, or your responsibility.

MEDICALLY NECESSARY CLAIMS WILL BE SUBMITTED TO INSURANCE
COPAYS ARE DUE AT TIME OF SERVICE
PAYMENT FOR COSMETIC RELATED ISSUES ARE DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECK, VISA/MASTERCARD

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY- We will file insurance claims according to our agreement with the insurance companies. We will not become involved in disputes between you and your insurance company regarding deductible, copayments, covered charges, secondary insurance, "usual and customary" charges, etc. other than to supply factual information as necessary.

YOU ARE RESPONSIBLE FOR TIMELY PAYMENT OF YOUR ACCOUNT- I understand that I am financially responsible for all charges whether or not paid by my insurance. If my account has become delinquent for 120 days, I will be sent to the collection agency with an additional 22%.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY

SIGNATURE: X _____**DATE:**_____

Calcagno & Rossi Vein Treatment Center

Health History

Name: _____Date:_____

Current Medications: **please** ☑

Name:_____Dose:_____ Oral:_____ Inj:____
Name:_____Dose:_____ Oral:_____ Inj:____
Name:_____Dose:_____ Oral:_____ Inj:____
Name:_____Dose:_____ Oral:_____ Inj:____
Name:_____Dose:_____ Oral:_____ Inj:____
Name:_____Dose:_____ Oral:_____ Inj:____
Name:_____Dose:_____ Oral:_____ Inj:____
Name:_____Dose:_____ Oral:_____ Inj:____

Known Allergies:

Name:_____

Name:_____

Name:_____

Name:_____

Past Surgical History:

Procedure:_____Date:_____

Procedure:_____Date:_____

Procedure:_____Date:_____

Procedure:_____Date:_____

Procedure:_____Date:_____

Previous Hospitalizations:

Date:_____Reason:_____

Date:_____Reason:_____

Patient Signature: **X**_____Date:_____

(the health history information I provided is true and correct to the best of my belief.)

Health History Questionnaire

Have you ever had any of the following? Please darken the appropriate circles.

Varicose veins	O Yes	O No
Leg pain	O Yes	O No
Leg aching	O Yes	O No
Leg heaviness	O Yes	O No
Leg tiredness	O Yes	O No
Leg fatigue	O Yes	O No
Leg itching	O Yes	O No
Leg burning	O Yes	O No
Leg swelling	O Yes	O No
Leg cramps	O Yes	O No
Leg throbbing	O Yes	O No
Leg skin discoloration	O Yes	O No
Current/healed skin ulcer	O Yes	O No

Does medicine help leg pain?	O Helps	O Doesn't help	O Haven't tried
Does elevation of legs help?	O Helps	O Doesn't help	O Haven't tried
Do support hose or stockings help?	O Helps	O Doesn't help	O Haven't tried

Have you had any significant or unexplained:

Bleeding problems	O Yes	O No
Weight change	O Yes	O No
Fever	O Yes	O No
Cough	O Yes	O No
Shortness of breath	O Yes	O No
Chest pain	O Yes	O No

Have you had any significant or unexplained:

Nausea	O Yes	O No
Rashes	O Yes	O No
Hives	O Yes	O No
Tingling or numbness	O Yes	O No
Easy bleeding	O Yes	O No
Depression	O Yes	O No
Migraines	O Yes	O No
Fatigue	O Yes	O No

Social History:

Smoking status: O current smoker O former smoker O nonsmoker

O current every day smoker O current some day smoker

O smoker, current status unknown O unknown if ever smoked

Alcohol O Yes O No

Marital status O married O single O divorced O separated O widow(er)

Family History:

Is there a family history of either of these conditions?

Mother	O varicose veins	O blood clots
Father	O varicose veins	O blood clots
Siblings	O varicose veins	O blood clots

Past Medical History:

Have you ever had any of the following?

Asthma	O Yes	O No
Hypertension	O Yes	O No
High Cholesterol	O Yes	O No
Diabetes	O Yes	O No
Congestive Heart Failure	O Yes	O No
Atrial Fibrillation	O Yes	O No
Depression	O Yes	O No
Vasculitis	O Yes	O No
DVT (blood clot)	O Yes	O No
Seizures	O Yes	O No
HIV	O Yes	O No
Hepatitis B	O Yes	O No
Hepatitis C	O Yes	O No

Have you ever had your veins treated with any of the following?

Sclerotherapy (vein injections)	O Yes	O No
Laser	O Yes	O No
Vein stripping	O Yes	O No
Vein ablation	O Yes	O No