VEIN & COSMETIC
CENTER OF TAMPA BAY

PATIENT NAME:_____ **DATE:**_____

Sex:_____ Date of Birth: _____ Social Security # _____

Best Contact Number (_____)_____ E-mail address_____

Marital Status:_____ Driver's License #:_____

LOCAL ADDRESS: _____

City_____ State_____ Zip_____

EMPLOYER:_____ WORK PHONE: _____

Occupation: _____

SPOUSE'S NAME: _____

Spouse's Employer: _____ Spouse's Work number:_____

How were you referred to our office (Please specify):_____

Insurance section needs to be filled out by Vein Patients ONLY

PRIMARY INSURANCE (Please Provide card to be copied): ☐ ☐

Company Name:_____ Through Employer? YES NO

Mailing Address:_____

Policy Number:_____ Group Name/Number:_____

SECONDARY INSURANCE (Please provide card to be copied): ☐ ☐

Company Name:_____ Through Employer? YES NO

Mailing Adress:_____

Policy Number:_____ Group Name/Number:_____

PAYMENT AGREEMENT/ASSIGNMENT OF BENEFITS/RELEASEOF INFORMATION:

I understand, whether agent or patient, that;

- Payment is due at the time of service, unless other arrangements were made in advance.
- If a contractual agreement exists between Vein Center of Tampa Bay and a third party payor (ie: Insurance, Medicare, ect.), that I am responsible for all deductibles and copays at the time of service as prescribed by my health coverage.
- I am responsible for any costs incurred in the collection of this account in case of default, including reasonable attorney fees and/or court costs, and that a late fee in the amount of 1.5% per month (not to exceed 18% annually) will accrue on delinquent "patient due" balances over 60 days.
- I hereby instruct that my Insurance Company pay Vein Center of Tampa Bay directly the professional/medical expense benefit allowable and payable to me under my current insurance policy as payment towards the total charges for the professional services rendered.
- I authorize Vein Center of Tampa Bay and/or the physician to furnish my insurance company and/or responsible third payor, or their representatives, any medical information necessary to process claims from this office.

_____ _____

SIGNED **DATE**

MEDICAL HISTORY

Name: _____ **Date:** _____

CHECK, IF YOU HAVE HAD ANY OF THE FOLLOWING:

Asthma	☐	Headaches	☐		
Diabetes	☐	Fainting	☐		
Stroke	☐	Epileptic	☐		
Heart Disease	☐	Nocturnal Calf Cramps	☐		
Rheumatic Fever	☐	Leg Pain	☐	Left ☐	Right ☐
Mitral Prolapse	☐	Varicose Veins	☐		
Open Heart Surgery	☐	Leg Ulcers	☐		
Short of Breath	☐	Ankle/Leg Swelling	☐		
High Blood Pressure	☐	Superficial Phlebitis	☐		
Hepatitis	☐	Hip Surgery	☐		
Dizziness	☐	Past Sclerotherapy	☐		
Liver Disease	☐	Knee Surgery	☐		
Past Varicose Vein Surgery	☐				

CHECK IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING:

Iodine	☐	Lidocaine	☐	
Seafood	☐	IVP Dye	☐	
Asprin	☐	Antibiotics ☐	Please List:	_____

Other Medications: _____

DO YOU TAKE COUMADIN, HEPARIN OR ASPIRIN? Y ☐ N ☐ List: _____

ARE YOU PREGNANT OR NURSING? _____ **PLANNING A PREGNANCY?** _____ **DATE OF LAST MENSTRAL PERIOD:** _____

LIST ALL MEDICATIONS YOU ARE NOW TAKING: _____

FAMILY PHYSICIAN: _____ Phone #: _____ City: _____

ARE YOU PLANNING ANY SURGERIES IN THE NEAR FUTURE? _____

IS THERE ANY OTHER INFORMATION YOU FEEL MAY BE IMPORTANT? _____

_____ _____

SIGNED **DATE**

VEIN & COSMETIC
CENTER OF TAMPA BAY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____

Please PRINT name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Other (Please specify)

_____

_____

_____

Witness: Print Name: _____

Signature: _____ Date: _____

Marketing Consent Form

VEIN & COSMETIC
CENTER OF TAMPA BAY

1. **FIRST PLEASE TELL US HOW YOU HEARD ABOUT US?** (Please check all that apply AND fill in the blank):

- ☐ **Vein Center Website**
- ☐ **Google Search Procedure Name** _____
- ☐ **Other Search Engine:** _____
- ☐ **Magazine/Newspaper:** _____
- ☐ **Other:** _____
- ☐ **Friend/Family Member (Please provide name:)** _____
- ☐ **Day Spa/Hair Salon (please provide name)** _____
- ☐ **Physician (Please provide name)** _____

2.

YES – Please send me information about special offers, promotions and events.

Please note: Your e-mail address is for our private use only and will never be shared, sold or traded.
Supplying your e-mail address allows us to:

- **Send you our Birthday Bucks $ certificate to celebrate your birthday.**
- **Send you monthly specials, discounts and invitations to our events.**
- **To notify you of your appointment or changes to your appointment if you can't be reached by phone.**

PRINT Name: _____

PRINT E-mail: _____@_____

Signature: _____ **Date:** _____

OR

NO – Do NOT send me information on special offers, promotions and events.

Please note: By signing NO, you may be excluded from offers that are available exclusively to our mailing list clients only.

PRINT Name: _____

Signature: _____ **Date:** _____

VEIN & COSMETIC
CENTER OF TAMPA BAY

Aesthetic H&P

Name:_____ Date:_____

DOB:_____

Allergies: Drugs/Latex:_____

Lidocaine Sensitivities:_____

Current Medications:_____

Surgeries: (General and/or Cosmetic) _____

Pregnant or Nursing: Yes or No

Alcohol: Y or N Freq: Smoking: Y or N Freq: Tobacco: Y or N Freq:

Hx of Hernia? Yes or No

Metal or Electrical Devices? Yes or No (If yes, circle below)

Screws Pins Metal Mesh Pacemaker Cardiac Devices

Autoimmune Disease:

Accutane Use: Yes or No Last used:_____

HIV, Hepatitis or HSV (Herpes Simplex Virus)? (Circle)

Are you on aspirin therapy?_____

Are you currently using any Rx topicals? (ie Retin A) _____

Health Assessment for Men

Name: _____ **Date:** _____

E-Mail: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

Health Assessment for Women

Name: _____ **Date:** _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		