# Medical – Health History Form

**Patient Name:** _____ **DOB:** _____ **Patient #** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Home Phone:** _____ **Cell Phone:** _____ **Preferred #: (circle) Home or Cell**

**Email:** _____ **May we add you to our email list?: (circle) Yes No**

**Referring Physician:** _____ **Primary Care Physician:** _____

**Reason for Visit:** _____

There exists a risk if our staff is not aware of the general health and medical background of a patient, and in order to provide you with the most appropriate treatment, we need you to complete the following questionnaire and please notify us of any changes that occur. All information is strictly confidential.

## Health Assessment:

**Height: _____ft. _____in.** **Weight: _____lbs.** **Have you lost weight recently?: (circle) Yes No**

**If yes, how much? _____lbs.**

## Family History:

| Has any blood relative ever had? | Relation | Yes | No | | Relation | Yes | No |
|---|---|---|---|---|---|---|---|
| Varicose Veins | | | | Bleeding Problems | | | |
| Heart disease | | | | Asthma | | | |
| Stroke | | | | High blood pressure | | | |
| Cancer | | | | Diabetes | | | |
| Vascular Problem | | | | Heart Attack | | | |

## Social History:

**Do you use Tobacco:**
☐ Current ☐ Former ☐Never
**Type:** ☐ Cigarettes ☐ Chewing ☐ None
**Years Used: _____Year Quit: _____ Packs/Day: _____**

**Exercise level:** ☐ Sedentary ☐ Moderate ☐ Heavy
**Caffeine Intake:** ☐ Never ☐ Moderate ☐ Heavy
**Alcohol Intake:** ☐ Never ☐ Moderate ☐ Heavy
**Drug Abuse:** ☐ Never ☐ Current ☐ Former

## Allergies / Medications you are allergic to: Reaction:

_____ ☐ Mild ☐ Moderate ☐ Severe _____
_____ ☐ Mild ☐ Moderate ☐ Severe _____
_____ ☐ Mild ☐ Moderate ☐ Severe _____
_____ ☐ Mild ☐ Moderate ☐ Severe _____

**LIST ALL MEDICATIONS YOU ARE TAKING: PRESCRIPTION, OVER THE COUNTER MEDICATIONS, AND HERBALS. INCLUDE MEDICATIONS TAKEN AS NEEDED. NOTE IF MEDICATION WAS STOPPED.**

| Date | Name of Medication/Dose | Directions (Do Not Abbreviate) | Reason for Taking/Dr. Name |
|---|---|---|---|
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**Check if you have history of the following:**

| | | |
|---|---|---|
| ☐ Arthritis | ☐ Hypertension | ☐ Kidney Disease |
| ☐ Heart Disease | ☐ Heart Attack | ☐ Liver Disease/Cirrhosis |
| ☐ Heart Palpitations | ☐ Epilepsy/Seizures | ☐ Thyroid Disease |
| ☐ Emphysema | ☐ Asthma | ☐ Cancer |
| ☐ Stroke | ☐ Diabetes | ☐ Bleeding |
| ☐ Other medical issues: | | |

**Surgical History, Hospitalizations with approximate date:**

**List any prior imaging studies you may have had related to this issue. Please include the date and location:**

**Please share any other pertinent medical information we may need to know:**

# Vein and Laser Institute
# Privacy Disclosure Information Authorization

I, _____, have been offered or received the Privacy Notice for Vein and Laser Institute and signed the authorization for the following:

Please list below whom we can speak with and release information to:
(Medical Records release will need to be signed)

| Family or Friend Name | Relationship to patient | Phone Number | Leave messages/speak with: | Review your account with: | Ok to pick up prescriptions, order, and medical records |
|---|---|---|---|---|---|
| | | | | | |
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I allow message to be left on the phone number I provided on the patient information form.

_____ YES _____ NO

Patient Portal: I consent to participate in the PATIENT PORTAL and understand that my personal health and individually identifying information is made available to me and/or my designee in the web-based portal application. I understand that I am responsible for safeguarding my access information, and should I choose to provide access to an Authorized Representative, they would have the same ability to perform all the same functions I am able to perform.

EMAIL: _____

Patient Signature: _____ Date: _____

Relationship to Patient: _____

Refusal of above: _____ Date: _____

# ***Financial Policy***

Thank you for choosing the Vein and Laser Institute! Our Physicians and staff are committed to the success of your medical treatment and care.

Please understand that payment of your bill is considered a part of your treatment and care. The following statement explains our Financial Policy which we ask you to read, sign and return to us prior to your treatment.

All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.

All applicable co-pays, personal balances, both current and prior, are due at the time of service.

We accept cash and credit/debit cards: Visa, Mastercard, American Express and Discover. We also accept Care Credit.

**Regarding Insurance**: We participate in ***most*** insurance plans, however we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. ***This includes policy deductible, co-insurance, copays or benefit limits***. It is your responsibility to understand and comply with any Pre-Determination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under your insurance policy.

**Initials: _____**

**Past due accounts:** I/We agree to pay all attorney fees, court costs, filing fees and all collections cost, up to 50% of the amount owing, which may be assessed by any collection agency retained to pursue the matter. **Initials: _____**

**Co-Pay Balances:** Payment for all co-pays and out of pocket expenses pre-determined is expected at time of service.

**Returned Checks**: For checks returned to us as unpaid by your bank, we will charge you a $50.00 fee. Please contact our office if you have any questions at (219) 736-8118.

**Cancellation/ No-Show Policy:** if an appointment is not cancelled at least 24 hours in advance, or you "no-Show" on the day of your scheduled appointment, you will be charged a $ 50.00 fee.
**THIS WIL NOT BE COVERD BY YOUR INSURANCE COMPANY.**

**Initials: _____**

I have read the Financial Policy. I understand and agree to the Financial Policy.

_____

**Print Name**

_____ _____

**Patient Signature** **Date**