

PENNSYLVANIA VASCULAR ASSOCIATES

SOCIETY HILL VEIN CENTER

PATIENT INFORMATION

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip code \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Patients Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Marital Status \_\_\_ S \_\_\_ M \_\_\_ Wid \_\_\_ Sep \_\_\_ Div \_\_\_

Spouse Name \_\_\_\_\_ Spouse Date of Birth \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

What Doctor referred you to our practice? \_\_\_\_\_

Referring Dr. Address \_\_\_\_\_

Referring Dr. Phone \_\_\_\_\_ Fax# \_\_\_\_\_

PRIMARY Doctor \_\_\_\_\_

Primary Dr. Address \_\_\_\_\_

Primary Dr. Phone \_\_\_\_\_ Fax# \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Relationship to You \_\_\_\_\_ Phone # \_\_\_\_\_

Please bring to the office with you the day of your visit. Thank you!

INSURANCE INFORMATION  
(PLEASE PRINT)

NAME OF PRIMARY INSURANCE \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME OF SUBSCRIBER \_\_\_\_\_ RELATIONSHIP TO SUBSCRIBER \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

NAME OF SECONDARY INSURANCE \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME OF SUBSCRIBER \_\_\_\_\_ RELATIONSHIP TO SUBSCRIBER \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

**FOR PATIENTS WITH MEDICARE COVERAGE PLEASE READ AND SIGN.**

I request payment of authorized Medicare benefits be made on my behalf to Pennsylvania Vascular Associates, P.C., or for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Agency and its agents any information needed to determine the benefits or the benefits payable for related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I also request that payment of authorized Medigap benefits be made on my behalf to Pennsylvania Vascular Associates, P.C. for any services furnished me by that physician. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits payable for related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**FOR PATIENTS WITH COMMERCIAL/ANY OTHER INSURANCE PLEASE READ AND SIGN.**

To process my medical claims for payment I hereby authorize Pennsylvania Vascular Associates, P.C. or his authorized agents, to release copies of my medical records and/or provide information regarding my physical or mental condition and treatment rendered to my insurance carrier and/or agent acting on the insurance carrier's behalf. I understand that these records and/or information may include psychiatric/psychotherapy, mental health, drug and/or alcohol information or treatment records, and I authorize the release of such records and/or information to my insurance carrier and/or agent acting on the insurance carrier's behalf.

I hereby assign Pennsylvania Vascular Associates, P.C. all payment for medical services rendered to myself and/or my dependents, and I understand and agree that any services not covered by my insurance company are my responsibility to pay.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*SOCIETY HILL VEIN CENTER*

Date \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ M F  
Blood Type \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_  
Referred by \_\_\_\_\_

**PERSONAL MEDICAL HISTORY (CURRENT COMPLAINT) CHECK ALL THAT APPLY.**

1. Are you consulting for

- Cosmetic purposes \_\_\_\_\_
- Medical reasons \_\_\_\_\_
- Both \_\_\_\_\_

2. How many years have you noticed this problem? \_\_\_\_\_

3. Have you ever been treated for this problem by:

- Injection/Sclerotherapy \_\_\_\_\_
- Laser \_\_\_\_\_
- Surgery \_\_\_\_\_

4. Have you ever been treated for one of the following?

Phlebitis (clotting of a vein) \_\_\_\_\_

Right leg \_\_\_\_\_ Left leg \_\_\_\_\_

Hospitalization? \_\_\_\_\_

Leg Ulcer \_\_\_\_\_

Right leg \_\_\_\_\_ Left leg \_\_\_\_\_

Date \_\_\_\_\_

Pulmonary Embolization (DVT) \_\_\_\_\_

Hospitalization? \_\_\_\_\_

Leg Fracture \_\_\_\_\_

5. When did your veins occur?

Age \_\_\_\_\_

Before Pregnancy \_\_\_\_\_

During Pregnancy (which one) \_\_\_\_\_

What are the ages of your children? \_\_\_\_\_

After trauma \_\_\_\_\_

Other \_\_\_\_\_

6. Are you developing new veins? Yes \_\_\_\_\_ No \_\_\_\_\_

7. Are your present veins getting bigger? Yes \_\_\_\_\_ No \_\_\_\_\_

8. Indicate which of the following problems you have experienced:

Pain in your	Right leg	Left leg
Lower limbs	_____	_____
Thigh	_____	_____
Calf	_____	_____
Leg	_____	_____
Foot	_____	_____
Swelling of the legs	_____	_____
Ulcer or Bleeding	_____	_____

9. If you experience pain in your lower limbs. Is the pain exacerbated by:

Extended periods in standing position \_\_\_\_\_

Heat \_\_\_\_\_

Menstrual periods \_\_\_\_\_

Exercising and/or walking \_\_\_\_\_

Intercourse \_\_\_\_\_

Is the pain alleviated by:

Elevation of the limbs \_\_\_\_\_

Elastic stockings \_\_\_\_\_

Walking and/or exercising \_\_\_\_\_

Indicate the type of pain

Resting pain \_\_\_\_\_

Resting cramps \_\_\_\_\_

Night cramps \_\_\_\_\_

Tiredness \_\_\_\_\_

Heaviness in the legs \_\_\_\_\_

Pain in the specific areas \_\_\_\_\_

Numbness \_\_\_\_\_

Burning sensation \_\_\_\_\_

Additional comments \_\_\_\_\_  
\_\_\_\_\_

10. Do you have a family history of:

Varicose veins \_\_\_\_\_

Blood clots/pulmonary embolism \_\_\_\_\_

Blood coagulation abnormality \_\_\_\_\_

11. Do you have a history of

Diabetes \_\_\_\_\_

High blood pressure \_\_\_\_\_

Seizures or convulsions \_\_\_\_\_

Fainting or dizziness \_\_\_\_\_

Stroke \_\_\_\_\_

- Asthma \_\_\_\_\_
- Hives \_\_\_\_\_
- Arthritis \_\_\_\_\_
- Autoimmune disease  
(e.g., Lupus) \_\_\_\_\_
- Hepatitis \_\_\_\_\_
- Bleeding disorders \_\_\_\_\_
- Easy bruisability \_\_\_\_\_
- Migraine headaches \_\_\_\_\_
- Dark spots after pregnancy  
skin injury or surgery \_\_\_\_\_

Do you have a personal history of allergies to medications? Please list drug and type or reaction.

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- Allergies to any foods \_\_\_\_\_
- Allergies or sensitivity to adhesive tape \_\_\_\_\_
- Have you ever had local anesthetic injection? \_\_\_\_\_

12. Does your work require a
- Prolonged standing position \_\_\_\_\_
  - Prolonged sitting position \_\_\_\_\_

13. In the course of a normal day, how much time is spent in a standing position?
- |                 |       |                 |       |
|-----------------|-------|-----------------|-------|
| 10% of the day  | _____ | 50 % of the day | _____ |
| 20 % of the day | _____ | More than 50 %  | _____ |

14. Do you jog, run, jump rope or do aerobics at least weekly? \_\_\_\_\_

15. Are you pregnant or planning a pregnancy soon? \_\_\_\_\_

16. Do you smoke cigarettes? \_\_\_\_\_

If yes, how many packs per day? \_\_\_\_\_

17. Have you worn elastic support stockings? \_\_\_\_\_

18. List all medications (including aspirin)

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19. List all previous surgeries

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20. List all allergies

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21. List all other medical problems

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