



ADVANCED VEIN & LASER CENTER

# ADVANCED VEIN & LASER CENTER REGISTRATION FORM

(Please Print)

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	Email Address:			Birth date: / /	Age: /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			City:		State & ZIP:	
Home phone #:		Cell Phone#:		Social Security #:		
Occupation:		Employer:		Employer phone #: ( )		
Chose office because/Referred to office by (please check one box):			<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Office Sign	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:						

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist at first appointment.)						
Is the patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance		<input type="checkbox"/> Highmark	<input type="checkbox"/> Capital Blue Cross	<input type="checkbox"/> Blue Cross / Blue Shield	<input type="checkbox"/> Health America/ Health Assurance	<input type="checkbox"/> MEDICARE
<input type="checkbox"/> Cigna	<input type="checkbox"/> Geisinger	<input type="checkbox"/> Aetna	<input type="checkbox"/> South Central Preferred		<input type="checkbox"/> Other	
Subscriber's name:		Subscriber's S.S. #:	Birth date: / /	Group #:	Policy or ID #:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group #:	Policy #:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IN CASE OF EMERGENCY				
Name:		Relationship to patient:	Home phone #: ( )	Work phone #: ( )
The above information is true to the best of my knowledge. I hereby authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the Advanced Vein and Laser Center or insurance company to release any information required to process my claims.				
_____ Patient/Guardian signature			_____ Date	

**PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME  
PLEASE BRING SHORTS TO ALL OF YOUR APPOINTMENTS**

Patient Name: \_\_\_\_\_

The following information is very important to your health. Please take time to fully and completely fill out this important information.

### Present Medical History (R.O.S.)

#### General

Change in appetite	yes	no
Change in weight	yes	no

#### Eyes

Glaucoma	yes	no
Change in vision	yes	no
Double vision	yes	no

#### Respiratory

Cough	yes	no
Shortness of breath	yes	no
Wheezing	yes	no
Asthma	yes	no
Difficulty breathing	yes	no

#### Digestive System

Abdominal Pain	yes	no
Nausea	yes	no
Heartburn	yes	no

#### Urinary System

Difficulty urinating	yes	no
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#### Nervous System

Dizziness	yes	no
Loss of consciousness	yes	no
Seizures	yes	no
Numbness/Tingling	yes	no
Stroke	yes	no
Nervous Exhaustion	yes	no
Blackouts	yes	no

#### Emotional Status

Nervousness	yes	no
Mood changes	yes	no
Insomnia	yes	no
Depression	yes	no
Schizophrenia	yes	no

#### Head

Frequent Headaches	yes	no
Recent Trauma	yes	no

#### Ears/Nose

Loss of Hearing	yes	no
Bleeding	yes	no
Nose Bleeding	yes	no

#### Heart

Heart Disease	yes	no
Chest Pain	yes	no
Chest Tightness	yes	no
High Blood Pressure	yes	no
Palpitations	yes	no
Elevated Cholesterol	yes	no
Difficulty breathing w/ activity	yes	no

#### Muscles/Bones

Pain	yes	no
Weakness	yes	no
Joint/Limb swelling	yes	no
Backache	yes	no
Degenerative Disease	yes	no
Difficulty walking	yes	no
Arthritis	yes	no

#### Skin

Skin Cancer	yes	no
Rash	yes	no
Non-Healing skin ulcer	yes	no

#### Endocrine/Glands

Thyroid	yes	no
Heat Intolerance	yes	no
Cold Intolerance	yes	no

#### Blood/Lymph system

Anemia	yes	no
Bruise easily	yes	no
Blood Transfusions	yes	no
Swollen glands	yes	no
Hepatitis	yes	no
HIV	yes	no
Bleed easily	yes	no

Patient Name: \_\_\_\_\_

**MEDICATIONS**

Please list below, or attach a list, of all current medications, including the medication name, dosage and frequency.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS SURGERY (please list)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES TO MEDICATIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT/PAST MEDICAL HISTORY**

Cardiovascular (heart)	yes	no
Pulmonary	yes	no
Gastrointestinal	yes	no
Neurological	yes	no
AIDS/HIV/Blood Related	yes	no
Diabetes/Thyroid	yes	no
Mental Disorder	yes	no
Musculoskeletal	yes	no
Hepatitis	yes	no
Cancer	yes	no
Other _____	yes	no

**ALLEGIES – FOOD/ENVIROMENTAL**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

Use of Tobacco	_____
Never	_____
Chews	_____
Currently Smoking – Packs per day?	_____
Previously Smoked – When Quit?	_____

**FAMILY HISTORY**

Heart	yes	no
Blood Pressure	yes	no
Diabetes	yes	no
Bleeding Disorder	yes	no
Cancer	yes	no
Auto-Immune Disease	yes	no
Arthritis	yes	no
Osteoporoses	yes	no
High Cholesterol	yes	no
Varicose Veins	yes	no
Other _____	yes	no

**ALCOHOL HISTORY:**

Never	_____
Occasional	_____
Moderate	_____
Heavy (Daily)	_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I need.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_

## VEIN DISEASE QUESTIONS

Reason for your visit:

Do you have a family history of Varicose Veins/ Spider Veins?

yes no

When did you first notice these veins?

Have you taken pain medication or any other medications for your Varicose Veins?

yes no

If yes, what medications have you taken?

Does your pain or discomfort affect your activities of daily living (ADL) or your ability to work?

yes no

If yes, describe how they are affected

Are you required to be on your feet or to sit for long periods of time?

yes no

Are you developing any new veins?

yes no

Have you used any type of prescription compression or support garments?

yes no

If yes, how long have you used the compression?

Have you had any vein treatment?

yes no

If yes, what types of vein treatment have you had?

Do you develop any cramps while walking?

yes no

If yes, where do you develop the cramps?

Do you have pain while at rest?

yes no

What have you done on your own to alleviate your discomfort? (ex: rest, elevation, avoidance of activities)

### **Do you now have or have you had: (if yes circle appropriate leg)**

Unightly Veins	Left	Right
Aches and pains	Left	Right
Heaviness or leg tiredness	Left	Right
Ankle edema or leg swelling	Left	Right
Itching	Left	Right
Night cramps	Left	Right
Bleeding from veins	Left	Right
Pigmentation (discoloration)	Left	Right
Dermatitis (eczema)	Left	Right
Ulceration	Left	Right
Superficial phlebitis	Left	Right
Deep Thrombophlebitis	Left	Right
Pulmonary emboli	Left	Right

If you have any questions regarding any of the information on this form, please discuss with the Advanced Vein and Laser Staff at your first appointment.

The above history and symptoms have been reviewed and addressed.

\_\_\_\_\_  
Steven B. Heird, MD

\_\_\_\_\_  
Date

**Notice of Information Practice**  
**PATIENT COPY – PLEASE KEEP FOR YOUR RECORDS**

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*This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.*

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1. Advanced Vein & Laser Center may use and disclose protected health information for treatment, payment, and health care operations. Examples of these include, but are not limited to, life insurance, physicals, and referral to nursing homes, home health agencies, and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers and collection agencies. Health care operations include, but are not limited to, internal quality control and assurance including auditing of records.
2. Advanced Vein & Laser Center is permitted or required to use or disclose protected health information without the individuals' written consent or authorization in certain circumstances, such as for public health requirements and court orders.
3. Advanced Vein & Laser Center will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
4. Advanced Vein & Laser Center may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient. If this contact is made by phone and you are not available, a message will be left on your answering machine.
5. Advanced Vein & Laser Center will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.
6. Advanced Vein & Laser Center reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.
7. Advanced Vein & Laser Center will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of the next visit or at the last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
8. Any person/patient may file a complaint to the medical practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, or for further information, please contact the privacy officer at the following address and/or telephone number.

Advanced Vein & Laser Center  
Attn: Practice Manager  
191 Leader Heights Road  
York, PA 17402  
717-741-2214.

9. It is Advanced Vein & Laser Center's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual noncompliance of the privacy standards.

## Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I understand that as part of my health care, Advanced Vein & Laser Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the medical practice reserves the right to change its notice and practices and before implementation will mail a copy of any revised notice to the address I have provided upon request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the medical practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the medical practice has already taken action in reliance thereon.

- I request the following restrictions to the use or disclosure of my health information.

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Signature of Patient or Legal  
Representative

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Date

- Accepted     Denied

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AVLC Acceptance Signature

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Title

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Date

## PHOTO CONSENT FORM

Subject to the conditions herein, I, the undersigned, hereby give my permission for use of photographs taken during the course of my treatment provided reasonable measures are taken to protect my identity and provided these photographs are used solely for ethical purposes which may include:

1. The use and publication of the photographs in whole or in part, individually or in conjunction with other photographs, in any medium for any purpose including medical records, professional journals, medical textbook, art, illustration, promotion, advertising or trade.
2. It is understood that the use of the photographs is for illustrating cosmetic procedures and demonstration of benefits. It is also understood that the use of the photographs will in no way reveal my identity.
3. The aforementioned photographs may be modified at the discretion of the facility, its clients, or agents to be more desirable. This will include, but will not be limited to, masking of the photographs to prevent identification or to cover private parts of the body.

I hereby release The Advanced Vein and Laser Center, its clients, and agents) from any and all claims and demands arising out of or in connection with the use of the aforesaid photographs.

I am of legal age.

I have read the foregoing document and fully understand its contents.

Name \_\_\_\_\_

Signature \_\_\_\_\_

Areas photographed \_\_\_\_\_

Areas photographed \_\_\_\_\_