784 Prince Ave
Athens, Georgia 30606
TEL: 706-208-1144
FAX: 706-208-9668
www.maffeiveincenter.com

Welcome to **Maffei Vein Center**
Dr. Maffei and staff would like to welcome you to our practice. We look forward to helping you with your vascular needs.

Please read the enclosed packet carefully and fill out the paper work prior to your appointment. Please find an enclosed envelope to mail the paperwork back to us. Remember to bring your insurance card(s) and a picture ID. **If you have an insurance plan which requires a referral from your primary care physician, please have your physician's office contact our office with the referral before your appointment date.**

An appointment time has been set aside especially for you. Should you need to cancel or reschedule your appointment, please give our office appropriate notice. **A cancellation notice of 48 hours for patient appointments and procedures is required.** Failure to adhere to the cancellation policy will result in a financial penalty of $50 for office visits and $100 for procedure visits, including sclerotherapy.

Thank you!

Appointment Date & Time: _____

PATIENT INFORMATION

Today's Date: _____/_____/20_____

Name: _____

Address: _____

_____

Telephone: Home: (_____) _____ Cell: (_____) _____

Employer: _____

Address: _____

Telephone: Work :(_____) _____

Date of Birth: _____ Sex: _____

Social Security #:_____

Marital Status: _____

Spouse's Name: _____

Spouse's Number :(_____) _____

Spouse's Employer: _____

EMERGENCY CONTACT:_____

Phone Number: (_____) _____ Relationship: _____

INSURANCE: Primary:_____

Secondary: _____

What Hospital Does Your Insurance Require For Treatment And/ Or Surgery?

Athens Regional Medical Center Saint Mary's Hospital

Referring Doctor: Specialist: _____

Primary Care: _____

Consent for Disclosure to Family Member and/ or Personal Representative

I have agreed to let certain individuals participate in the discussions and decisions related to my medical care. Therefore, I hereby give my permission for Athens Thoracic & Vascular Surgery, Dr. Maffei and his office staff to disclose my personal medical information to the following individual (s):

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Conditions for Disclosure (check the item(s) that apply)

_____ The Practice may disclose my personal health information to the individual(s) above ONLY in my presence.
_____ The Practice may disclose my personal health information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.
_____ Other Conditions of Disclosure_____

I understand that this consent is in effect until revoked by me by written notice to the practice.

Patient Signature _____ Date: _____
Witnessed By _____ Title: _____
Print Name of Witness _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Right to Request Restrictions: You have the right to request a restrictions or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or a friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

To request restrictions, you must make your request in writing. In your request you need to indicate:

1. **What information you want to limit.**
2. **Whether you want to limit use, disclosure or both.**
3. **To whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)**

Right to Request Confidential Communications: You have the right toe request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, or the like.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Effective Date
This notice is effective as of JANUARY 1 2014.

Acknowledgment of Receipt
Notice of Privacy Practices

Your signature acknowledges that you have received a copy of the Notice of Privacy Practices.
Patient Name_____
Signature: _____ _____ Date_____

PATIENT HISTORY

Date: ____/____/____

Name: _____ D.O.B: _____/____/_____ Age: _____

Please check leg symptoms you currently have or
Have experienced in the past 3 months:

	Right	Left
No symptoms	☐	☐
Aching	☐	☐
Restlessness	☐	☐
Heaviness	☐	☐
Itching	☐	☐
Burning	☐	☐
Cramping	☐	☐
Throbbing	☐	☐
Fatigue	☐	☐
Swelling	☐	☐
Other_____	☐	☐

Do your symptoms interfere with sleep? ☐Yes ☐No
Do they interfere with walking? ☐Yes ☐No

On a scale of 1-10, with 1 being slightly bothersome and 10 being severely affecting my life, I consider my vein disease to be:

1 2 3 4 5 6 7 8 9 10

Are your varicose or spider veins located in another area besides your leg? If so, where?

_____
_____

Please check if you have ever had:

	Right	Left
☐ leg ulcers	☐	☐
☐ bleeding from a vein	☐	☐
☐ blood clot/phlebitis	☐	☐
☐ vein surgery	☐	☐
☐ prior vein eval./treatment	☐	☐
☐ vein injections	☐	☐
☐ leg injury/trauma	☐	☐

Please Check Yes or No

I have tried elevation of my legs to relieve discomfort for _____ months ☐Yes ☐No

I have tried elastic support/compression stockings
☐ Yes ☐ No How Long? _____

I have taken medication for my leg symptoms
☐ Yes ☐ No

If yes: what medication? How long?
_____

Standing makes my symptoms worse. ☐ Yes ☐ No
I stand _____ hours per day.

Please specify if you exercise and if so, how frequent:

_____

Please list any surgeries and *dates:*
(Other than vein surgeries)

_____
_____
_____
_____
_____
_____

Please list your occupation:

_____

For Women Only**:**
Are you pregnant or considering pregnancy in the near future? ☐ Yes ☐ No
Are you breastfeeding? ☐ Yes ☐ No
Worsening of symptoms during pregnancy? ☐ Yes ☐ No
Number of pregnancies?_____Deliveries? _____
Do you use birth control pills or take estrogen replacement therapy? ☐ Yes ☐ No

Medications:

(Please include all prescriptions, over the counter, herbal remedies, vitamins and dietary supplements)

Medication	Dosage	How Often

Medication Allergies: □ None Known

_____
_____
_____
_____

Allergic to: □ Latex/Rubber □ Betadine/Iodine

Are you a smoker? _____

If yes, how much do you smoke per day and for how long have you smoked (months or years)?

_____

PATIENT'S PERSONAL HISTORY

Last Name_____ First Name_____ Middle_____

DATE OF BIRTH:_____

DO YOU HAVE OR HAVE YOU HAD: (Please circle yes or no. If yes, provide date of occurrence).

No Yes ____ Cancer

HEAD AND NECK

No Yes ____ Tonsillitis

NEURO

No Yes ____ Seizures
No Yes ____ Stroke
No Yes ____ Epilepsy
No Yes ____ Migraine
No Yes ____ Tremors

PULMONARY

No Yes ____ Tuberculosis
No Yes ____ Bronchitis
No Yes ____ Pneumonia
No Yes ____ Hay Fever
No Yes ____ Exposure to Asbestos
No Yes ____ Blood Clot in Lung

CV

No Yes ____ Heart Attack
No Yes ____ Heart Failure
No Yes ____ Rheumatic Heart Disease
No Yes ____ Congenital Heart Problem
No Yes ____ High Blood Pressure

ENDOCRINE

No Yes ____ Thyroid Disease
No Yes ____ Diabetes

GI/GU

No Yes ____ Hepatitis
No Yes ____ Gall Bladder Disease
No Yes ____ Stomach Ulcers
No Yes ____ Pancreatic Disease
No Yes ____ Kidney Disease
No Yes ____ Bladder Infection

MUSCULOSKELETAL

No Yes ____ Arthritis
No Yes ____ Poor Circulation
No Yes ____ Gout

DERM

No Yes ____ Psoriasis
No Yes ____ Dermatitis
No Yes ____ Eczema

COAGULOPATHY

No Yes ____ Bleeding Tendency
No Yes ____ High Fever After Blood Transfusion
No Yes ____ Blood Clots

PSYCH

No Yes ___ Nervous Breakdown

DO YOU KNOW OF ANY BLOOD RELATIVE WHO HAS OR HAS HAD (Circle yes or no. If yes, give relationship)

No Yes _____ Tuberculosis
No Yes _____ Seizures
No Yes _____ Stroke
No Yes _____ Cancer
No Yes _____ Epilepsy
No Yes _____ Diabetes
No Yes _____ Hepatitis
No Yes _____ Arthritis
No Yes _____ Migraine

No Yes _____ Hay Fever
No Yes _____ Gall Bladder Disease
No Yes _____ Thyroid Disease
No Yes _____ Asthma
No Yes _____ Heart Attack
No Yes _____ Heart Failure
No Yes _____ Stomach Ulcers
No Yes _____ Kidney Disease
No Yes _____ Rheumatic Heart Disease

No Yes_____ Congenital Heart Problem
No Yes_____ Bleeding Tendency
No Yes_____ High Blood Pressure
No Yes_____ Blood Clots
No Yes_____ Poor Circulation
No Yes_____ Nervous Breakdown
No Yes _____Suicide

_____

Physician's Signature Date

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REGARDING PRIOR AUTHORIZATION, PRECERTIFICATIONS, AND BENEFITS VERIFIED BY OUR OFFICE STAFF:

Although every effort is made to make sure we obtain all current and valid information regarding your medical insurance information, it is ultimately your responsibility to know your insurance benefits and limitations. Most insurance companies provide a disclaimer that state: any information provided may not reflect changes made to the insurance plan within the last 30 days.

Pre-determination of benefits does not guarantee payment. Benefits are always subject to other applicable requirements such as pre-existing conditions, limitations and exclusions of your insurance plan, payments of premium and eligibility at the time of care for services that are provided, and participating and/or network provider status.

We advise you to know your insurance benefits and check with your insurance plan should you have any questions about your benefits.

I have read and understand the information given to me above.

Patient name: _____ Date of birth: _____

Patient signature: _____ Date: _____

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Authorization to Release Healthcare Information

Patient's name: _____
Previous name: _____

Purpose of Release: ____ Continuing Care ____ Copies for own use ___ Transition of Care

____ Legal

I request and authorize _____
to release healthcare information of the patient named above to:

Maffei Vein Center
Dr. Vincent Maffei
784 Prince Ave
Athens, Georgia 30606

(Please list your primary care physician or Dr. who possesses pertinent medical records regarding your treatment with Dr. Maffei above)

This request and authorization applies to:
_____ Healthcare information related to the following treatment, condition, or dates:
_____
_____

_____ All healthcare information

_____Other: _____

Patient name: _____ Date of birth: _____

Patient signature: _____ Date: _____

Signature of
Responsible party: _____ Date: _____

CANCELLATION POLICY

EFFECTIVE January 1, 2016

TIME HAS BEEN SPECIFICALLY RESERVED FOR YOUR APPOINTMENT, PROCEDURE, OR TREATMENT; PLEASE CALL AT LEAST 2 BUSINESS DAYS AHEAD OF TIME IF YOU MUST CANCEL AN APPOINTMENT. THERE IS A $50 CHARGE FOR OFFICE VISITS AND $100 CHARGE FOR PROCEDURE VISITS, INCLUDING SCLEROTHERAPY VISITS IF YOU DO NOT SHOW UP FOR A SCHEDULED APPOINTMENT OR CANCEL WITHIN 2 BUSINESS DAYS PRIOR TO YOUR SCHEDULED APPOINTMENT.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO COMPLY WITH THE TERMS OF YOUR OFFICE/FINANCIAL POLICY AND CANCEELLATION POLICY.

PATIENT SIGNATURE: _____ DATE: _____

Maffei Vein Center

Vincent J. Maffei, M.D.

How Did You Hear About Us?

(Circle all that apply)

Magazine(s)	Radio	Internet	Other
Lake Living	Magic 102.1 FM	Web Search Engine	Billboard(s)
		Facebook	
		Twitter	

Did you hear about us from a different source that is not listed above? If so, please list your reference(s):_____

Were you referred by a Dr.? If yes, who?

Were you referred by a friend or former patient? If yes, who?

Thank you for choosing the Maffei Vein Center for your healthcare needs.