PLEASE PRINT

APPOINTMENT DATE: APPOINTMENT TIME:

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

| Allergies: | Social Security no.: | Birth date: / / | Age: | Sex: M / F |
|---|---|---|---|---|

| Street address: | Home phone no.: ( ) | Cell phone no.: ( ) |
|---|---|---|

| P.O. box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Occupation: | Employer: | Employer phone no.: ( ) |
|---|---|---|

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

## PLEASE LIST REFERRING & PRIMARY CARE PHYSICIAN

| Referring Physician: | Primary Care: |
|---|---|
| Phone: | Phone: |

## IN CASE OF EMERGENCY

| Name of local friend or relative (not at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

## INSURANCE INFORMATION

Predermination of benefits does not guarantee payment. Any remaining balance is the patient's responsibility. We advise you to know your insurance benefits and check with your insurance plan should you have questions regarding your benefits.

| Primary Insurance: | Subscriber's name: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

| Secondary Insurance: | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

# Office visits and procedures must be cancelled or rescheduled 48 hours prior to appointment time to avoid cancellation fees.

Office visit cancellation fee: $50.00 Procedure cancellation fee: $100.00 Sclerotherapy cancellation fee: $ 100.00

By signing below, I acknowledge that I have read, understand, and agree to comply with the terms of your office/ financial policy and cancellation policy.

*Patient/Guardian signature* *Date*

## 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 restriction 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 2017

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______________________________

784 Prince Ave
Athens, Georgia 30677
TEL: 706-208-1144
FAX: 706-208-9668
www.maffeiveincenter.com

## 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: ______________________

**PATIENT HISTORY**

**NAME:** ______________________________

**DOB:** _______________ AGE: ____________

| Check current leg symptoms <u>OR</u> Symptoms experienced over the past 90 days | Right | Left |
|---|---|---|
| No symptoms | | |
| Restlessness | | |
| Aching | | |
| Heaviness | | |
| Itching | | |
| Burning | | |
| Cramping | | |
| Throbbing | | |
| Fatigue | | |
| Swelling | | |
| Other: | | |

| Check if you have ever had: | Right | Left |
|---|---|---|
| Leg ulcers | | |
| Bleeding from a vein | | |
| Blood clots/Phlebitis | | |
| Prior vein surgery | | |
| Prior vein evaluation/Treatment | | |
| Vein injections | | |
| Leg injury /Trauma | | |

| Do you have varicose or spider veins located in areas other than your legs? **Where**? ____________ | **Yes** | **NO** |
|---|---|---|
| Do your symptoms interfere with sleep? | | |
| Do they interfere with walking? | | |
| Does standing make symptoms worse? **How many hours do you stand daily**? ______ | | |
| Have you tried elevating legs to relieve discomfort? **How long**? ____________ | | |
| Have you worn elastic support/ compression stockings? **How long**? ____________ | | |
| Do you exercise? **How often**? ____________ | | |
| Have you taken medication for leg symptoms? **How long**? ____________ **What medication**? ____________ | | |

**DATE**: ______________________________

On a scale of 1-10, with 1 being slightly bothersome and 10 being severely affecting your life, rate your vein disease: 1 2 3 4 5 6 7 8 9 10

**Please list any other previous surgeries and dates:**
(Excluding vein surgeries)

______________________________

______________________________

______________________________

______________________________

**Medications**: (Include prescription, OTC, supplements)

| Medication | Dosage | How Often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

List additional medications on back / OR attach a list

**Medication Allergies:** Latex/Rubber _____ Betadine______

______________________________

______________________________

**No known medication allergies** ______

Do you smoke?________ If yes, how much do you smoke and how long have you smoked? ______________

Please list your work occupation:

______________________________

**For Women Only**:

Are you pregnant or considering pregnancy in the near future? ___________

Are you breastfeeding? ___________

Do symptoms get worse during pregnancy?

Number of pregnancies: _______ Deliveries: _________

Do you use birth control pills or take estrogen replacement therapy? ___________

# 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