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

Unpaid balances transfer to a collection agency if a payment is not made within 60 days of billing date

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 _____ Hay Fever
No Yes _____ Gall Bladder Disease
No Yes _____ Thyroid Disease
No Yes _____ Asthma

No Yes_____ Congenital Heart Problem
No Yes_____ Bleeding Tendency
No Yes_____ High Blood Pressure

No Yes _____ Epilepsy
No Yes _____ Diabetes
No Yes _____ Hepatitis
No Yes _____ Arthritis
No Yes _____ Migraine

No Yes _____ Heart Attack
No Yes _____ Heart Failure
No Yes _____ Stomach Ulcers
No Yes _____ Kidney Disease
No Yes _____ Rheumatic Heart Disease

No Yes_____ Blood Clots
No Yes_____ Poor Circulation
No Yes_____ Nervous Breakdown
No Yes _____Suicide

_____

Physician's Signature Date