VICTORIA VEIN &
SURGERY CLINIC

PATIENT INFORMATION FORM

PATIENT INFORMATION

Patient Name: _____
Sex: M [ ] F [ ] *First* *Middle Initial* *Last*

Email address:_____

Patient's SS#: _____ Date of Birth: ____/_____/_____Race:_____

Address: _____ City: _____ State _____

Zip _____ -____ Home #( )_____-_____ Cell #( ) _____-_____ Work #( ) _____-_____

RESPONSIBLE PARTY (*If Minor /Responsible Party*)

Responsible Party Name (if different than patient)_____
Sex: M [ ] F [ ] *First* *Middle Initial* *Last*

Name: _____ DOB ____/_____/_____SS# _____-_____-_____

Emergency Contact: _____ Home #( )_____-_____
Relationship_____

INSURANCE INFORMATION

Primary Insurance Name: _____ Name of Insured: _____
ID or Policy Number: _____ Group Number: _____
Insurance Phone #_____ Effective Date:_____

Secondary Insurance Name: _____ Name of Insured: _____
Id or Policy Number: _____ Group Number: _____
Insurance Phone #_____ Effective Date:_____

INSURANCE AUTHORIZATION & ASSIGNMENT:

I authorize Sean M. Hamilton, MD with Victoria Vein & Surgery Clinic to furnish information to insurance carriers concerning my medical condition and care. I assign to Sean M. Hamilton, MD all payments for medical services rendered to me or my dependents. I also request payment of government benefits to the party who accepts assignment. This authorization is valid as long as I am a patient of Sean M. Hamilton M.D.

Any person signing below guarantees payment of the health care costs incurred on behalf of patient and in the event such costs are not incurred on behalf of patient and in the even such costs are not timely paid further guarantee payment of the cost of collection of such bills including attorney fee's. collection agencies and interest.

_____ _____
Signature ***Signature Date***
The signature is of the: ____Patient ____Parent of Minor ____Legal Guardian ____Patient's Power of Attorney

We reserve the right to charge a no-show fee of $10.00 if you fail to notify our office of your cancellation within 24 hours of your appointment. Insurance will not cover this fee.

Victoria Vein & Surgery Clinic
Patient Medical History

Name: _____ Date of Birth: _____

Patient Referred by: _____ **Reason for Referral**: _____

Race: Check the appropriate box
White(Non-Hispanic)___ Hispanic___ Black___ Asian___ American Indian___ Pacific Islander___ Other___

Primary Care Physician_____ Pharmacy_____ Phone:_____

Past Medical History: Please list any medical problems you have:
1. _____ 2. _____ 3 ._____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Surgical History/ Trauma History: List any operations or injuries along with month, year and hospital
1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Have you or any family members ever had a reaction to anesthesia? _____ Bleeding Problems? _____

Medications: List the medications you are currently taking along with the dosages, include nonprescription items such as St. John's Wort, dietary supplements, diet pills, cold and flu medications, etc.
1. _____ 2._____ 3._____
4. _____ 5._____ 6._____
7. _____ 8. _____ 9. _____

Have you taken the following in the last month? Prednisone____ Coumadin ____Aspirin/ Motrin/ Naprosyn ____

What meds are you ALLERGIC to? _____

Review of Systems: Check the appropriate box if you have had these symptoms recently

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	Fevers	___	___	Calf Pain	___	___	Upper Abdominal Pain	___	___	Nipple discharge
___	___	Night Sweats	___	___	Short of breath (SOB)	___	___	Lower Abdominal Pain	___	___	Headache or migraine
___	___	Fatigue	___	___	SOB with ex	___	___	Painful urination	___	___	Room spinning
___	___	Vision changes	___	___	SOB at night	___	___	Blood in urine	___	___	Seizures
___	___	Double vision	___	___	Wheezing	___	___	Straining on urination	___	___	Passing out
___	___	Hearing loss	___	___	Cough, sputum	___	___	Kidney stones	___	___	Numbness or tingling
___	___	Ringing in ears	___	___	Coughing blood	___	___	Pelvic pain	___	___	Memory loss
___	___	Ear pain or drainage	___	___	Diarrhea	___	___	Vaginal discharge/bleeding	___	___	Anxiety
___	___	Bloody nose	___	___	Constipation	___	___	Joint or muscle pain	___	___	Depression
___	___	Nasal discharge	___	___	Stool incontinence	___	___	Decreased mobility, weakness	___	___	Suicidal thoughts
___	___	Sinusitis	___	___	Black tar-like stools	___	___	Joint swelling	___	___	Excessive hair growth
___	___	Sore throat	___	___	Bloody stools	___	___	Skin rash	___	___	Excessive thirst
___	___	Hoarseness	___	___	Difficulty swallowing	___	___	Itching	___	___	Excessive urination
___	___	Oral ulcers	___	___	Heartburn	___	___	Mole changes	___	___	Easy bruising
___	___	Chest pain	___	___	Nausea	___	___	Loss of hair	___	___	Bleeding tendency
___	___	Palpitations	___	___	Vomiting	___	___	Difficulty w/ nails	___	___	Swollen nodes
___	___	Ankle swelling	___	___	Irregular Pulse	___	___	Vomiting blood	___	___	Breast lumps, pain

Menstrual History: Are you pregnant? ____ Number of Pregnancies ____ Live births ___
Miscarriages____ Age of first pregnancy ____ Do you take birth control pills? ___ Age of Menopause ____

Social History: Marital status: _____ Number of children _____ International travel? _____
Occupation: _____ Do you do heavy lifting on a daily basis? _____
Cigarette Smoking: I have smoked _____ packs per day for _____ years. Quit smoking in _____ Drug use? ____
Please describe your alcohol intake: _____None____ Occasional ____ 1-2 drinks per day _____ >2 drinks per day
Family History: Check the box if you have first degree relatives with the following cancers (Ca) or diseases:
Breast Ca ___ Ovarian Ca ___ Colon Ca ___ Skin Ca ___ Lymphoma ___ Leukemia __ Inflam. Bowel Disease ___
Brain tumors ___ Heart disease ___ Thyroid Disease ___ Parathyroid disease ___ Other _____

VICTORIA VEIN & SURGERY CLINIC

Consent to Photograph for Medical Communication with Insurance Company

Patient Name: _____ Date: _____

The undersigned authorizes Victoria Vein & Surgery Clinic to take and reproduce photographs of the above named person in communication with diagnosis, care and treatment. Use of such materials and the person's name is also authorized for use in dealing with the named person's insurance company, including filing claims, medical necessity and appeals with said insurance company.
_____ Initial to indicate that you have read, understand, and approve authorization as stated above.

I release the Victoria Vein & Surgery Clinic and Sean M. Hamilton, M.D., employees, and consultants from any liability in connection with the use of such materials. I understand that this authorization will remain effective unless revoked in writing.
Patient's Signature: _____ Date: _____
Phone Number: _____
Legal Guardian' Signature if patient is under 18: _____
Witness' Signature: _____ Date: _____

I, _____have read and understand the HIPAA Notice of Privacy Practices of Dr. Sean M. Hamiton's office.
____ I want a copy of the HIPAA Privacy Policy
____ I do not want a copy of the HIPAA Privacy Policy

I have given permission for the office of Dr. Sean M. Hamilton to discuss my medical history/condition with the following person(s):
Name: _____ ____ Limited Time/ Date ending _____ or Until rescinded____

Patient Signature: _____ Date: _____

Victoria Vein & Surgery Clinic

Patient please complete questions 1-12

Patient Name: _____ Date of Birth: _____

Directions: Please answer the following questions. Provide estimates for date of occurrence.

Past Medical History

1. Have you ever had vein stripping surgery ☐ Yes ☐ No
   If yes, when and which leg? _____
2. Have you ever had vein injections? ☐ Yes ☐ No
   If yes, which leg and where on the leg? _____
3. Have you ever had a blood clot? ☐ Yes ☐ No
   If yes, which leg and when? _____
4. Have you ever had phlebitis? ☐ Yes ☐ No
   If yes, which leg and when? _____

Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

Father	☐ Yes	☐ No
Mother	☐ Yes	☐ No
Brother(s)	☐ Yes	☐ No
Sister(s)	☐ Yes	☐ No
Other	☐ Yes	☐ No

1. Do you experience any of the following in your legs?

Aching/pain? ☐ Yes During activity or prolong standing ☐ Yes ☐ No ☐ LT / RT leg ☐ Both legs

Heaviness? ☐ Yes During activity or prolong standing ☐ Yes ☐ No ☐ LT / RT leg ☐ Both legs

Tiredness/fatigue? ☐ Yes During activity or prolong standing ☐ Yes ☐ No ☐ LT / RT leg ☐ Both legs

Itching/burning? ☐ Yes During activity or prolong standing ☐ Yes ☐ No ☐ LT / RT leg ☐ Both legs

Swollen ankles? ☐ Yes During activity or prolong standing ☐ Yes ☐ No ☐ LT / RT leg ☐ Both legs

Leg cramps? ☐ Yes During activity or prolong standing ☐ Yes ☐ No ☐ LT / RT leg ☐ Both legs

Restless legs? ☐ Yes During activity or prolong standing ☐ Yes ☐ No ☐ LT / RT leg ☐ Both legs

Throbbing? ☐ Yes During activity or prolong standing ☐ Yes ☐ No ☐ LT / RT leg ☐ Both legs

VAS Scale -Rate the intensity of pain_____ Persistent ☐ Yes ☐ No

2. Have your veins gotten worse in recent months? ☐ Yes ☐ No
   Describe: _____

3. Do you take any medication for pain (i.e., Advil, Motrin) ☐ Yes ☐ No
   If yes, what medication(s) do you take and how many times/mgs per day? _____
   _____

4. Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No
   If yes, how long per day do you elevate and does it provide relief?_____

5. Do you exercise? ☐ Yes ☐ No
   If yes, what kind of exercise and how often? _____

6. Do you wear prescription compression stockings? ☐ Yes ☐ No
   If yes, what type and gradient? How long have you worn them? _____
   _____

   If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? _____

7. Do you wear light support hose (i.e., Sheer Energy)?
   If yes, do they provide relief? ☐ Yes ☐ No

8. Do you have any problem walking? ☐ Yes ☐ No
   If yes, describe how it interferes with your activities of daily living, which activities? (worse at night, after standing/sitting long periods or after exercise) _____
   _____

9. What type of work do you do? _____
   How long do you stand (hours per day) at work? _____ At home? _____
   Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: (inability to walk or stand for long hours)_____
   _____

10. Have you ever had any test(s) done on your veins? ☐ Yes ☐ No
    If yes, when and what type of test and where on the leg? _____
    _____

11. Were you diagnosed with saphenous vein reflux? ☐ Yes ☐ No

12. Name of referring Physician and how long have you been under his care for treatment of this condition?
    _____

Patient Signature: _____Date:_____