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: _____