Elite
HEART • LUNG • VEIN
SURGEONS

Patients full name _____ Age _____Date of Birth _____Sex M/F

SS #_____ Race_____ Ethnicity _____Email _____

Home Phone #_____Cell_____Martial Status_____DL#_____

Address_____City_____State _____Zip_____

Contact Preference: Home/Cell/Email/Text Please initial that you have received the HIPPA Policy_____

Pharmacy Name _____Phone #_____

Employer_____Phone# _____

Emergency Contact_____ Phone #_____ Relationship_____

Parent/Legal Guardian (if under 18) _____

Referring Physician _____ Family Physician _____

Primary Insurance

_____

Name Claims Address Policy #

Secondary Insurance

_____

Name Claims Address Policy #

Others we can speak with regarding your care (this must be completed for us to discuss your medical care with anyone

besides yourself)_____

I agree that the information supplied on this from is accurate and up to date to the best of my knowledge. I hereby authorize EHLVS to release any information acquired during my examination and treatment for insurance purposes. I hereby authorize any payment of medical or surgical benefits to be paid directly to the above name physicians for their services. I understand that I am financially responsible for any charge not covered by this authorization. A photostatic /fax copy of this authorization may be exhibited as proof of my consent. I consent to the procedures which may be performed during this outpatient visit, including emergency treatment of services and which may include but are not limited to laboratory procedures, diagnostic, medical or nursing treatment or other physician or clinical services rendered to me as ordered by my physician, PA or other healthcare professional. This includes testing for communicable or blood-borne diseases, including HIV, AIDS and Hepatitis if a physician orders such tests) for diagnostic and/or treatment purposes.

Patient Signature: _____Date_____

New Patient Information Form

Name _____ Date of Birth_____

Reason for Visit_____

PREVIOUS HOSPITALIZATIONS / SURGERIES

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

PATIENT SOCIAL HISTORY

Alcohol Use: Never____ Rarely____ Moderate____ Daily____

Tobacco Use: Never____ Previously____ Current____ # Packs per day_____

Drug Use: Never____ Previously____ Current____ Type/Freq. _____

FAMILY MEDICAL HISTORY

	Age		Deceased	Medical Problems
Father_____			No/Yes	_____
Mother____			No/Yes	_____
Sibling_____		Brother/Sister	No/Yes	_____
Sibling_____		Brother/Sister	No/Yes	_____
Sibling_____		Brother/Sister	No/Yes	_____

CURRENT MEDICATIONS

NAME	DOSAGE (MG)	FREQUENCY

CURRENT ALLERGIES

NAME	REACTION

PAST MEDICAL HISTORY
PLEASE CIRCLE ALL THAT APPLY

- AIDS/HIV
- Acid Reflux (GERD)
- Acute Infections
- Allergies/Hay fever
- Anemia
- Angioplasty
- Anticoagulation therapy
- Anxiety Disorder
- Arrhythmia
- Arthritis
- Asthma
- Atrial Fibrillation
- Bleeding Disorder
- Blood Clot
- Breast Cancer
- Bronchitis
- COPD
- Cancer
- Cardiac Arrest
- Cardiomyopathy
- Clotting Disorder
- Colon Cancer
- Congenital Heart Disease
- Congestive Heart Failure (CHF)
- Coronary Artery Disease
- Cystic Fibrosis
- Deep Vein Thrombosis
- Depression
- Diabetes
- Diverticulitis
- Emphysema
- Epilepsy/Seizures
- Gastrointestinal Disease
- Genitourinary Disease
- Gout
- Heart Attack (MI)
- Heart Disease
- Heart Murmur
- Heart Surgery
- Hepatitis
- High Cholesterol
- History of Blood Thinners
- Hyperlipidemia
- Hypertension
- Kidney Disease
- Liver Disease
- Lung Mass
- Mental Illness
- Multiple Sclerosis
- NSAID Use
- Neurologic Disorder
- Obesity
- Osteoporosis
- Other Cancer
- _____
- Pacemaker/AICD
- Pancreas Disease
- Peripheral Arterial Disease
- Pneumonia
- Pulmonary Embolism
- Restless Leg Syndrome
- Seizures/Epilepsy
- Sickle Cell
- Sinusitis
- Sleep Apnea
- Sleep Disorder
- Stent
- Stroke
- Thyroid Disease
- Thyroid Problems
- Transplants
- Tuberculosis
- Ulcers
- Urinary Incontinence
- Urinary Tract Infections
- Valvular Disease
- Varicose Veins
- Venereal Disease

_____ _____

PATIENT'S NAME **DATE OF BIRTH**

REVIEW OF CURRENT SYMPTOMS FOR TODAY'S VISIT

Patient Name: _____ Date of Birth: _____

CONSTITUTIONAL SYMPTOMS:

Recent Weight Change	NO	YES
Fever	NO	YES
Fatigue	NO	YES
Headaches	NO	YES

EYES:

Eye Disease or Injury	NO	YES
Wear Glasses/Contact Lenses	NO	YES
Blurred or Double Vision	NO	YES

EARS, NOSE, MOUTH, THROAT:

Hearing loss or Ringing	NO	YES
Earaches or Drainage	NO	YES
Chronic Sinus Problems/rhinitis	NO	YES
Mouth Sores	NO	YES
Bleeding Gums	NO	YES
Bad Breath or Bad Taste	NO	YES
Sore Throat or Voice Change	NO	YES
Swollen Glands in Neck	NO	YES

RESPIRATORY:

Chronic	NO	YES
Shortness of Breath	NO	YES
Asthma or Wheezing	NO	YES

CARDIOVASCULAR:

Murmur	NO	YES
Chest Pain or Angina Pectoris	NO	YES
Palpitations	NO	YES
Shortness of Breath	NO	YES
Edema / Swelling	NO	YES

GASTROINTESTINAL:

Loss of Appetite	NO	YES
Change in Bowel Movements	NO	YES
Nausea or Vomiting	NO	YES
Frequent Diarrhea	NO	YES
Painful Bowel Movements or Constipation	NO	YES
Rectal Bleeding or Blood in Stool	NO	YES
Abdominal Pain or Heartburn	NO	YES
Peptic Ulcers (Stomach or Duodenal)	NO	YES

GENITOUNARY:

Frequent Urination	NO	YES
Burning or Painful Urination	NO	YES
Blood in Urine	NO	YES
Change in Force of Strain When Urinating	NO	YES
Incontinence	NO	YES

INTEGUMENTARY (Skin and Breast):

Rash or Itching	NO	YES
Change in Skin Color	NO	YES
Change in Hair or Nails	NO	YES
Varicose Veins	NO	YES

NEUROLOGICAL:

Headaches	NO	YES
Dizziness	NO	YES
Convulsion or Seizure	NO	YES
Numbness or Tingling Sensation	NO	YES

PSYCHIACTRIC:

Memory Loss or Confusion	NO	YES
Nervousness	NO	YES
Depression	NO	YES
Insomnia	NO	YES

ENDOCRINE:

Excessive Thirst or Urination	NO	YES
Heat or Cold Intolerance	NO	YES
Skin Becoming Drier	NO	YES
Change in Hat or Glove Size	NO	YES

HEMATOLOGIC/LYMPHATIC:

Slow to Heal After Cut	NO	YES
Bleeding or Bruising	NO	YES
Past Blood Transfusions	NO	YES

Vein Screening Assessment

Patient Name: _____ **Date of Birth:** _____

Check all that apply:	**Left Leg**	**Right Leg**
Aching/Pain	☐	☐
Heaviness	☐	☐
Swelling	☐	☐
Skin discoloration	☐	☐
Restless legs	☐	☐
Throbbing	☐	☐
Symptoms relieved by rest/elevation	☐	☐

Have your veins gotten worse in recent months?
☐Yes ☐No

Do you take any medication for pain?
(i.e. Advil, Motrin) ☐Yes ☐No
If yes, what medication/dosage_____
_____

Do you elevate your legs to relieve discomfort?
☐Yes ☐No

Do you wear prescription compression stockings?
☐Yes ☐No

Have you ever tried exercising to relieve pain?
☐Yes ☐No

Have you ever had vein stripping surgery?
☐Yes ☐No

Have you ever had vein injections?
☐Yes ☐No

Have you ever had phlebitis?
☐Yes ☐No

Have you ever had a blood clot?
If yes, when and which leg? ☐Yes ☐No
_____

PHYSICIAN TO COMPLETE BELOW THIS POINT

CEAP CLASS – RIGHT LEG						
0	1	2	3	4	5	6
Asymptomatic	Spider Veins	Varicose Veins	Edema	Skin Changes	Healed Ulcer	Active Ulcer

CEAP CLASS – LEFT LEG						
0	1	2	3	4	5	6
Asymptomatic	Spider Veins	Varicose Veins	Edema	Skin Changes	Healed Ulcer	Active Ulcer

Etiology: ☐Congenital ☐Primary Disease ☐Secondary Disease

Anatomic Findings: ☐Superficial ☐Deep ☐Perforator

Pathophysiology Dysfunction: ☐Reflux ☐Obstruction ☐Both Reflux & Obstruction

☐**Prescribed Compression Stockings** ☐**Follow up with ultrasound**

Notes: _____

_____

_____

Physician Signature: _____ Date: _____

Cancellation Policy/ Authorization for Credit Card Payment

We understand there are times when you miss or need to reschedule appointments. Please realize we have a full schedule most days and try our best to accommodate every patient. However, when you do not cancel your appointment it could be preventing other patients from getting needed treatment.

As of March 1, 2018, we will require a **cancellation fee of $100 for surgery and $50 for office visit** when you are a "no show" or cancel in less than 24 hours from the appointment time. If for any reason our office cancels your appointment you will not be charged.

To reserve an appointment, we must have a credit card on- file or post-dated check so we are able to charge the cancellation fee if applicable.

****Please understand this is company policy and no exceptions will be made. ****

By signing below, I acknowledge my credit card will be charged $100/$50 on the next business day of any no show appointments.

Name (Print): _____

Signature: _____

Patient Name (if different from name on card): _____

Credit Card Number _____

Expiration Date: _____

CVV# _____