**AUSTIN VASCULAR & VEIN SPECIALISTS**

**DR. JOEL G. GOTVALD**

**PATIENT DEMOGRAPHICS**

**NEW PATIENT: \_\_\_\_\_\_ UPDATE: \_\_\_\_\_\_**

**PATIENT INFORMATION**:

PATIENT LEGAL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST FIRST

PREFERRED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SEX:** M / F AGE: \_\_\_\_\_

**D.O.B**\_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY NO.\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **MARITAL STATUS:** SINGLE/MARRIED/DIVORCED/WIDOWED/PARTNER

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT NO. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NO: HOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO WE HAVE PERMISSION TO?**

Y/N – ACQUIRE IMAGES/PHOTOS OF VEINS FOR MEDICAL RECORD PURPOSES? (photos are confidential as part of the medical record)

Y/N – LEAVE A MESSAGE ON ANSWERING MACHINE AT HOME?

Y/N – LEAVE A MESSAGE AT WORK?

Y/N – DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF YOUR HOUSEHOLD? IF SO:

PERSON: RELATIONSHIP:

**EMAIL**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **HOW DID YOU HEAR ABOUT US?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRING PHYSICIAN**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PRIMARY PHYSICIAN**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYER INFORMATION:**

**PLACE OF EMPLOYMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POSITION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NO. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION:**

PRIMARY INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS. PHONE NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_**

POLICY NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SOCIAL SECURITY NO.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO INSURED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE:**

PRIMARY INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS. PHONE NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

POLICY NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NO: HOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*PLEASE LET US KNOW IF YOU HAVE A THIRD INSURANCE\*\*\*\*

**ASSIGNMENT AND AUTHORIZATION OF BENEFITS**

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I hereby assign all medical and or/surgical benefits to which I am entitled, including Medicare, private insurance, and other plans to Austin Vascular & Vein Specialists. I understand that I am responsible for all charges, obtain reimbursement, I authorize disclosure of portions of the patient’s medical record. I authorize insurance claims filed and benefits assigned.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Personal Representative** **DATE**



**AUSTIN VASCULAR & VEIN SPECIALISTS**

**JOEL G. GOTVALD, MD, FACS, RPVI**

**Page 1 of 4 PATIENT HISTORY QUESTIONNAIRE**

PLEASE COMPLETE AND BRING THIS FORM WITH YOU TO YOUR FIRST APPOINTMENT

TODAY’S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTH DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_

REFERING PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REFERING PHONE NO. : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ANY/ALL OTHER DOCTORS YOU SEE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current Height? \_\_\_\_\_\_\_\_\_\_\_\_\_ Weight? \_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR YOUR VISIT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY OF PRESENT ILLNESS (HPI)** IF APPLICABLE

* **Location:** (Where on the body symptom occurs): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Duration:** How long have you had symptoms? How long does it last?) DATE OF ONSET: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

\_\_\_\_\_\_\_ DAYS, \_\_\_\_\_WEEKS, \_\_\_\_MONTHS, \_\_\_\_\_ YEARS

* **Severity:** no pain, mild, moderate, severe, pain level \_\_\_\_\_\_/10, worst pain \_\_\_\_\_\_\_/10, intermittent, constant:

(IF WORSE PLEASE EXPLAIN): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Quality:** edema/swelling, aching, burning, cramping discomfort, gnawing, stabbing, throbbing, sharp pain, dull pain, superficial pain, deep pain,

Occasional, frequent, constant, worsening, improving, not changing (IF OTHER PLEASE EXPLAIN): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Timing:** cannot identify , acute , chronic , abrupt , gradual , morning , daytime , nighttime , recurrent , rare , occasional , intermittent episodes lasting(**IF OTHER PLEASE EXPLAIN):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# ◊ Associated Signs/Symptoms: (Other things that happen when this symptom occurs) PLEASE CIRCLE

Appearance, Aching, Weakness, numbness, tingling, swelling, redness warmth, ecchymosis, dull pain, sharp pain, catching/locking, poping/clicking, instability, radiation down leg, drainage, fever, chills, pressure, leg swelling L / R or both, tiredness/easy fatigue, legs tire easily when standing, itching, restless legs, heaviness, burning, discoloration, cramps, tender to touch, throbbing, bleeding from veins, leg(s)ulcer, recurrent ulcer, rash **(IF OTHER PLEASE EXPLAIN):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# ◊ Alleviating Factors: (Things to make symptoms better) PLEASE CIRCLE

nothing helps , sitting , standing , lying down , position change , heat , ice , rest , elevation , stretching , limited weight bearing , PT/OT , chiropractic care , ESI , OTC medication , narcotics , NSAIDs , cortisone injection , vicosupplement injection , orthotics , previous surgery , brace , crutches , cane , wheelchair , walker , compression stockings, anti-inflammatories, other medications , exercise or

**(IF OTHER PLEASE EXPLAIN):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# ◊ Aggravating Factors: Signs/Symptoms: (what makes the symptom occur or get worse) PLEASE CIRCLE

Cannot identify, sitting, standing ,lying down, walking, lifting, carrying, twisting, bending,/squatting, pushing/pulling, throwing, ROM, weight bearing, exercise, computer use, changing clothes, getting out of bed, going from sit to stand, upstairs, downstairs, morning, daytime, nighttime, cold weather, damp weather, previous surgery, edema, previous childbirth or menstrual cycle

**(IF OTHER PLEASE EXPLAIN):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PRIOR IMAGING:** IF **(YES)** PLEASE ENTER DATES BELOW THAT MAY APPLY:

|  |  |  |  |
| --- | --- | --- | --- |
| VENOUS DOPPLER |  | ULTRA SOUND |  |
| VEIN MAPPING |  | ARTERIAL DOPPLER |  |
| CTA/CT SCAN |  | SEGMENTAL PRESSURES |  |
| ANKLE BRACHIAL INDEX |  | MRI/MRA |  |

EXISTING /PAST **Medical History:** Please circle **(YES)** if you have any of the following medical problems.

|  |  |  |
| --- | --- | --- |
| ANGIOGRAMS, CATHETERIZATION  **Yes** | GASTROINTESTINAL ULCER OR BLEEDING  **Yes** | LUNG, COPD/EPHYSEMA  **Yes** |
| AMPUTATIONS  **Yes** | GERD (REFLUX)  **Yes** | LUPUS  **Yes** |
| ANEMIA  **Yes** | GOUT  **Yes** | MIGRAINE HEADACHES  **Yes** |
| ANEURYSMS, SPECIFY LOCATION  **Yes** | HEART ARRYTHMIA /A –FIB  **Yes** | NEUROPATHY / NERVE INJURIES  **Yes** |
| ANGIOPLASTY IN PAST  **Yes** | HEART ATTACK  **Yes** | NUMBNESS  **Yes** |
| ARM PAIN  **Yes** | HEART CONDITIONS , OTHER  **Yes** | OBESITY  **Yes** |
| ARM SWELLING  **Yes** | HEART DISEASE  **Yes** | OSTEOARTHRITIS  **Yes** |
| ASTHMA  **Yes** | HEART FAILURE/CHF  **Yes** | RESTLESS LEG SYNDROME  **Yes**  |
| BACK PAIN , CHRONIC  **Yes** | HEART, CARDIOMYOPATHY  **Yes** | PAIN SYNDROME, CHRONIC  **Yes** |
| BLEEDING DISORDER, GENETIC  **Yes** | HEART, CORONARY ARTERY DISEASE  **Yes** | PERIPHERAL ARTERY DISEASE  **Yes** |
| BLOOD CLOTS / DVT  **Yes** | HEPATITIS OR HIV  **Yes** | PNEUMONIA  **Yes** |
| BLOOD CLOTS, PULMONARY EMBOLISM  **Yes** | HYPERCHOLESTEROLEMIA  **Yes** | POOR CIRCULATION, OTHER  **Yes** |
| BLOOD CLOT DISORDER, EASY CLOTTING  **Yes** | HYPERLIPIDEMIA /DYSLPIDEMIA  **Yes** | PSYC, ANXIETY DISORDER  **Yes** |
| BLOOD VESSEL PHLEBITIS  **Yes** | HYPERTENSION/HIGH BLOOD PRESSURE  **Yes** | PSYC, BIPOLOR  **Yes** |
| BYPASS SURGERY IN PAST  **Yes** | IMPLANTS IN BODY? TYPE  **Yes** | PSYC, DEPRESSION  **Yes** |
| CANCER, SPECIFY TYPE  **Yes** | INFECTIONS CURRENTLY?  **Yes** | PSYC, SCHIZOPHRENIA  **Yes** |
| CAROTID ARTERY DISEASE  **Yes** | KIDNEY DISEASE , OTHER  **Yes** | SKIN CONDITIONS  **Yes** |
| COAGULOPATHY/BLEEDING DISORDER  **Yes** | KIDNEY FAILURE  **Yes** | SPIDER VEINS  **Yes** |
| DEMENTIA **Yes** | KIDNEY CHORNIC RENAL INSUFFFICIENCY  **Yes** | STENTS IN PAST  **Yes** |
| DIABETES 1 **Yes** | KIDNEY RENAL FAILURE  **Yes** | STROKE OR TIA  **Yes** |
| DIABETES 2 **Yes** | LEG/FOOT DISCOLORATION  **Yes** | THORACIC OUTLET SYNDROME  **Yes** |
| DIALYSIS? WHICH DAYS?  **Yes** | LEG/FOOT PAIN  **Yes** | THYROID, HYPERTHYROIDISM  **Yes** |
| DISSECTION, ARTERY  **Yes** | LEG/FOOT , SWELLING  **Yes** | THYROID, HYPOTHYROIDISM  **Yes** |
| EDEMA, LEG/FOOT  **Yes** | LEG, GANGRENE IN PAST  **Yes** | ULCER OR WOUNDS  **Yes** |
| END STAGE RENAL DISEASE/DIALYSIS  **Yes** | LEG, NUMBNESS  **Yes** | VARICOSE VEINS  **Yes** |
| FIBROMYALGIA  **Yes** | LEG, ULCERS OR WOUNDS  **Yes** | WALKING DIFFICULTY  **Yes** |
| FOOT, GANGRENE IN PAST  **Yes** | LEG WEAKNESS  **Yes** | WALKER OR CANE? USE  **Yes** |
| FOOT ULCER  **Yes** | LIVER DISEASE  **Yes** | WHEELCHAIR USE  **Yes** |
| GASTROINTESTINAL PROBLEMS  **Yes** | LUNG DISEASE  **Yes** | LYMPHEDEMA  **Yes** |

Other (please Explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Past Hospitalizations/Surgeries and Approximate dates:** |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Family History:** Please list any medical problems in your relatives

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:** Marital Status: Single Married Separated Divorced Widowed

Tobacco Use: Never  Quit/When? \_\_\_\_\_\_\_\_\_\_\_\_ Age started \_\_\_\_\_\_\_

Smoker/how many packs per day? \_\_\_\_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_\_\_

Drug Use: Never Type and frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcoholic beverages? YES NO (# per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Do you exercise regularly? YES NO (# of days/week \_\_\_\_\_\_)

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Are you pregnant? Yes NO Number of Pregnancies \_\_\_\_\_\_ Number of Births\_\_\_\_\_\_ Are you trying to get pregnant? \_\_\_\_\_\_

Are you breastfeeding? Yes NO

Are you on any Current Birth Control Method? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you reside in a nursing home: Yes NO If yes, please name facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Do you take any of the following Medications?** | |  |
| **Aspirin Yes or No** | **Plavix** | **Yes or No** |
| **Lovenox Yes or No** | **Coumadin/Warfarin** | **Yes or No** |
| **Other blood thinners Yes or No**    **Current Medications:** | **Anti – Inflammatory** | **Yes or No** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

# Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Latex Yes or No Pain Medication Yes or No Seasonal Yes or No Antibiotics Yes or No Iodine Yes or No Sulfa Yes or No

**What type of reaction?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review of systems (Please check **YES** if you have any of the following problems).

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **◊ Constitutional** |  | | **◊ Ears/Nose/Mouth/Throat** | | | **◊ Eyes** |  | |
| Good General Health |  | Yes | Hearing loss or ringing |  | Yes | Wear glasses/contacts |  | Yes |
| Recent weight change |  | Yes | Sinus Problems |  | Yes | Blurred/double vision |  | Yes |
| Night sweats, fevers |  | Yes | Nose bleeds |  | Yes | Eye disease or injury |  | Yes |
| Fatigue |  | Yes | Sore throat/voice change |  | Yes | Glaucoma |  | Yes |
| **◊ Cardiovascular** |  |  | **◊ Respiratory** |  |  | **◊ Gastrointestinal** |  |  |
| Chest Pain |  | Yes | Shortness of breath |  | Yes | Nausea/vomiting |  | Yes |
| Palpitations |  | Yes | Cough |  | Yes | Abdominal pain |  | Yes |
| Heart trouble |  | Yes | Wheezing/asthma |  | Yes | Rectal bleeding |  | Yes |
| Swelling hands/feet |  | Yes | Coughing up blood |  | Yes | Bowel problems |  | Yes |
| **◊ Musculoskeletal** |  |  | **◊ Neurological** |  |  | **◊ Integumentary(Skin/Breast)** |  |  |
| Muscle pain or cramp |  | Yes | Frequent headaches |  | Yes | Change in hair or nails |  | Yes |
| Stiffness/swelling joints |  | Yes | Paralysis or tremors |  | Yes | Rashes or itching |  | Yes |
| Joint pain |  | Yes | Convulsions/seizures |  | Yes | Breast lump |  | Yes |
| Trouble walking |  | Yes | Numbness/tingling |  | Yes | Breast pain/discharge |  | Yes |
| **◊ Endocrine** |  |  | **◊ Hematologic/Lymphatic** |  |  | **◊ Coagulation** |  |  |
| Excessive thirst/urination |  | Yes | Bruise easily |  | Yes | Frequent Bruising |  | Yes |
| Thyroid |  | Yes | Slow to heal |  | Yes | Abnormal clotting |  | Yes |
| Hormone problem |  | Yes | Enlarged glands |  | Yes | Abnormal Bleeding |  | Yes |
| **◊ Genitourinary – Male Only** |  |  | **◊ Genitourinary – Female Only** |  |  | Bleeding after other operations |  |  |
| Blood in urine |  | Yes | Blood in urine |  | Yes | **◊ Psychiatric** |  | Yes |
| Kidney stones |  | Yes | Kidney stones |  | Yes | Insomnia |  | Yes |
| Sexual problems |  | Yes | Sexual problems |  | Yes | Confusion/Memory Loss |  | Yes |
| Testicle Pain |  | Yes | Menstrual problems |  | Yes | Depression |  | Yes |

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**Please be specific on how your vein symptoms limit or affect your activities of daily living:** (required by your Insurance).

* Limits and prevents me from standing long periods at work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Limits or prevents me from house hold chores: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do your symptoms affect your daily living if so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VEIN HISTORY**

**Have you had vein treatments before?** No Yes, when and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you first notice your enlarged or discolored veins? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where are the veins you are seeking a medical opinion located? Face Leg (s) (circle) Right Leg/Left Leg/ Both

Have you ever worn prescription grade compression stockings? No Yes, when and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a family history or vein problems? No, Yes, What family member? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please  next to the symptoms that apply to you: Aching Appearance Burning Cramps Dull Pain

Swelling Heaviness Itching Leg Ulcers Sharp Pain

Pressure Throbbing Tiredness  Tingling

# Name of Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL POLICY**

As we enter the doctor-patient relationship, we agree to provide quality healthcare at a fair and reasonable price, and you in turn, agree it is your obligation to understand your insurance benefits and be prepared to pay at the time of service. This is an explanation of our financial policy, so there are no unpleasant surprises.

* **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, MasterCard, Visa, American Express, Discover and Care Credit. We DO NOT ACCEPT CHECKS. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due ***prior*** to these services being provided. Any remaining balance after your health plans pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will note as “Self-Pay” and payment will be due in full. Account balance over 90 days with not payment activity will be reported to the credit bureau(s).

***Initial\_\_\_\_\_\_\_\_\_\_***

* **Your insurance policy is a contract between you and your insurer. It is your responsibility to know what your policy covers and what it does not although we will help you get the most out of your benefits.** When your coverage is verified by our office personal, we are given a disclaimer informing it is only a quote of benefits and not a guarantee of payment. Payment is determined once the claim is received and processed by your insurer. Any item deemed “Non-Covered” will be your financial responsibility. We do not accept ‘Usual and Customary’ payments. Any disputes about payment must be resolved between you and your insurer. You are responsible for ensuring a properly dated referral and/or authorization if required by your insurer for services being provided. It is your responsibility to make certain you have subsequent authorizations during ongoing treatment. You are also responsible for payment if your claim denies for lack of referral/authorizations.

***Initial\_\_\_\_\_\_\_\_\_\_***

* As a courtesy to you, we will file primary participating insurance for you with proper assignment. Insurance will not be accepted if presented after 3 business days from the date of your appointment. Any additional policies will be yours to file with your receipt from our office. Please bring your insurance card(s) with you to every and provide the front desk with any updated information at the time of check-in. All remaining balances are your responsibility to satisfy prior to additional services being rendered.

***Initial*\_\_\_\_\_\_\_\_\_\_**

* This office is not party to legal disputes or agreements. The financial responsibility rest with the patient.

***Initial\_\_\_\_\_\_\_\_\_\_***

* A $25.00 completion fee is collected for FMLA/Disability forms. This fee is charged per incident and collected at the time you request completion. Insurance Companies will not pay these fees.

***Initial\_\_\_\_\_\_\_\_\_\_***

* If you are 15 minutes late, your appointment will need to be rescheduled. You will be responsible for the missed appointment fee of **$85.00**. No Show/Late fees will be applied for appointments that are not cancelled 24 hours **PRIOR** to the appointment. New patient paperwork that is not completed by the appointment time will result in a missed appointment fee and the appointment will need to be rescheduled.

***Initial\_\_\_\_\_\_\_\_\_\_***

* Payments & credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding date(s) of service.

***Initial\_\_\_\_\_\_\_\_\_\_***

**ASSIGNMENT OF BENEFITS**

I request payment of the medical benefits, otherwise payable to me, directly to Joel Gotvald, MD, PA: Austin Vascular & Vein Specialists for services provided to them.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party, ***Printed Name*** (Must be 18 and over) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party, ***Signature***  (Must be 18 and over) Date