



# VEIN AND LASER CENTER

## Patient Health History Form

### Demographics

Patient Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

May we have your e-mail address? \_\_\_\_\_  
(We may send you e-mail news)

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Are you currently being treated by any other physician(s)?  No  Yes  
If yes, please list physician name(s) and phone number(s): \_\_\_\_\_

Current List of Medications:	Dosage:	How Often Medication is Taken/Directions:

Do you take over the counter medications (e.g., aspirin, ibuprofen, or a similar type of medication) or prescription medications for aching, cramping, burning, or swelling of the lower extremities? Please indicate medication and dosage: \_\_\_\_\_

Pharmacy Name and Phone Number: \_\_\_\_\_

Please list ALL allergies: \_\_\_\_\_

ARE YOU ALLERGIC TO IODINE OR LATEX? Please specify: \_\_\_\_\_

What is your profession? \_\_\_\_\_

Do daily activities require prolonged periods of standing?  No  Yes

If yes, what activity(ies) requires prolonged periods of standing? \_\_\_\_\_

If yes, how many times during the day does the patient have to sit or take a break due to aching, cramping, burning, itching, or swelling in the lower extremities? (Please answer as they were experienced PRIOR to any recent trial of compression stockings):

- None  1-2 times per day  3-4 times per day  4-5 times per day  6+ times per day

List all past surgeries and dates: \_\_\_\_\_

Are you pregnant?  No  Yes Number of Pregnancies \_\_\_\_\_ Number of Births \_\_\_\_\_

Are you taking oral contraceptives?  No  Yes Are you on hormone replacement therapy?  No  Yes

### Habits

Do you drink alcoholic beverages?  No  Occasionally  Moderately  Frequently

Do you now or have you ever used tobacco?  No  Yes (Packs per week \_\_\_\_\_)  
Quit date, if applicable \_\_\_\_\_

Do you exercise regularly?  No  Yes (Number of days per week \_\_\_\_\_)

### Vein History

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

Where are the veins you are seeking a medical opinion for located?  Face  Leg(s) -  Right leg  Left leg  
 Both legs

Have you ever worn prescription grade compression stockings?  No  Yes  
(When and for how long? \_\_\_\_\_ Months/Years)

Do you have a family history of vein problems?  No  Yes (What family member(s)? \_\_\_\_\_)

Please check the symptoms that apply to you:

<input type="checkbox"/> Aching leg(s)	<input type="checkbox"/> Appearance	<input type="checkbox"/> Burning	<input type="checkbox"/> Cramps
<input type="checkbox"/> Dull Pain	<input type="checkbox"/> Heaviness	<input type="checkbox"/> Itching	<input type="checkbox"/> Leg Ulcers
<input type="checkbox"/> Restless Legs	<input type="checkbox"/> Sharp Pain	<input type="checkbox"/> Swelling	<input type="checkbox"/> Throbbing
<input type="checkbox"/> Tiredness	<input type="checkbox"/> Other: _____		

Are your symptoms getting worse?  No  Yes (If yes, please explain)

Are your symptoms affecting your daily living activities?  No  Yes (If yes, please explain)

Describe aggravating factors (i.e., minimal exertion, walking, etc.) \_\_\_\_\_

Describe how symptoms are relieved (i.e., rest, medication, etc.) \_\_\_\_\_

Please check next to anything that applies to your past medical history:

Phlebitis (Clot in Surface Veins in Legs)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(If yes, when? _____)
Deep Vein Thrombosis (Clot in deep veins)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(If yes, when? _____)
Pulmonary Embolus (Blood clot in lungs)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(If yes, when? _____)
Bleeding from veins?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(If yes, when? _____)
Have you had Sclerotherapy before?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(If yes, when? _____)
Venogram (Vein X-Ray)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(If yes, when? _____)
Have you ever had vein surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(If yes, when? _____)
Trauma/Injury to your legs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(If yes, when? _____)
Clotting disorder?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(If yes, when? _____)
Venous ulcer?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(If yes, when? _____)

Please mark any of the following conditions you or a family member have EVER experienced:

Condition	Self	Family	Please Explain:
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal Moles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hives	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
COPD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina (Chest Pain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic/Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastric Reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastric Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pinched Nerve	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spinal Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke/Seizures/TIA	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes (Type )	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
IV Use	<input type="checkbox"/>	<input type="checkbox"/>	_____
AIDS/HIV/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____



**VEIN AND LASER**  
— C E N T E R —  
of Elgin Cardiac Surgery

**Insurance Information**

**Please complete the following information, then sign and date below.**

**Remember to bring a photo ID to your appointment so that our receptionist may make a copy with your insurance cards to keep in your file.**

Patient Name: \_\_\_\_\_

Patient Social Security Number (*required*): \_\_\_\_\_

**Primary Insurance Information**

Name of your primary insurance company: \_\_\_\_\_

Name of the policy holder: \_\_\_\_\_

Your relationship: \_\_\_\_\_

Date of birth of the policy holder (*required*): \_\_\_\_\_

Social security number of the policy holder (*required*): \_\_\_\_\_

Policy holder's employer: \_\_\_\_\_

Employer address: \_\_\_\_\_

Employer phone number: \_\_\_\_\_

**Secondary Insurance Information**  
**(If Applicable)**

Name of your secondary insurance company: \_\_\_\_\_

Name of the policy holder: \_\_\_\_\_

Your relationship: \_\_\_\_\_

Date of birth of the policy holder (*required*): \_\_\_\_\_

Social security number of the policy holder (*required*): \_\_\_\_\_

Policy holder's employer: \_\_\_\_\_

Employer address: \_\_\_\_\_

Employer phone number: \_\_\_\_\_

Specializing in:  
Varicose Vein Treatment &  
Treatment of all Venous Disorders

**Patient Signature**

**Date**

1435 North Randall Road, Suite 207, Elgin, Illinois 60120  
phone: 847.717.3265 fax: 847.695.1954

*Vein and Laser Center of Elgin Cardiac Surgery  
attained recognition for its commitment to providing  
high level patient care and quality testing for the  
diagnosis of vascular disease by the Intersocietal  
Commission for the Accreditation of Vascular  
Laboratories. (ICAVL)*

www.vlecs.com





# VEIN AND LASER — C E N T E R — of Elgin Cardiac Surgery

## FINANCIAL POLICY & BILLING INFORMATION

To help us provide the most efficient and reasonable health care services, it is necessary for us to have a financial policy stating our requirements for payment of services provided to patients. The *Vein and Laser Center* is committed to providing you with the best possible care. Charges for services rendered have been determined based on usual and customary fees for this area. If you have any questions in regard to your bill, please contact our billing office at (847) 695-5168. The doctor does not take calls in regards to your bill.

Patients are responsible for the payment of all services provided by the *Vein and Laser Center*. However, it is our policy to file your insurance as a courtesy if we have accurate and complete insurance information. Our relationship with your insurance company is important to us. Therefore, we cannot legally write off your co-pay, co-insurance, or deductible. If you need to make special payment arrangements, contact our billing office. If, however, your account is ever delinquent and placed with our collection service, and additional 33 1/3% of your outstanding balance will be added to the account.

Your health insurance is a contract between you and your insurance company. It is your responsibility to obtain a referral from your primary care physician if necessary. You are responsible for any balance not paid by the insurance company within 60 days. Please be aware that some services may not be covered by your insurance policy. As a courtesy to you, if you need a surgical procedure, our office will do a pre-determination of benefits. The purpose of this pre-determination is to establish medical necessity. The pre-determination requires: consultation note from the surgeon, ultrasound report, photographs, and our letter stating the procedures you will require along with your diagnosis.

In order for the *Vein and Laser Center* to create a treatment plan specifically for you, an ultrasound will be performed in the office. Since your insurance company will require this information to do your pre-determination, the ultrasound will be billed to your insurance company. On the day of surgery, our office will be happy to submit your claim for you. It is important to understand that you will be responsible for any unmet deductibles, co-pays, or co-insurance payments. All payments for spider vein treatments, compression stockings, and medications will be collected at time of visit. No claims will be submitted for these.

If your insurance company requires a pre-certification, please call your insurance company to let them know the date of your surgery. It is expected that if your insurance company sends payment to you directly, you will mail the check with the EOB to our office promptly. Once we receive payment, any office discounts that apply will be offered at that time.

- **Assignment of Insurance Benefits:** I hereby authorize direct payment of benefits to the *Vein and Laser Center* for services rendered.
- **Authorization for Release of Information:** I hereby authorize the *Vein and Laser Center* to release any medical information necessary for the processing of my insurance claim if requested by my insurance company.

I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay any attorney's fees, court costs, and related collection fees incurred should it become necessary to refer my account to a collection agency.

Specializing in:  
Varicose Vein Treatment &  
Treatment of all Venous Disorders

Patient or Responsible Party Signature

Date

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