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PATIENT REGISTRATION FORM

[Please print or write legibly]

LAST NAME:_____FIRST NAME:_____MI:_____

GENDER: ☐ MALE ☐ FEMALE DATE OF BIRTH: _____SOCIAL SECURITY:_____

MAILING ADDRESS:_____APT.#_____

CITY:_____STATE:_____ZIP_____

PLEASE CHECK YOUR PREFERRED PRIMARY PHONE NUMBER:

☐ HOME:_____ ☐ WORK:_____ ☐ MOBILE:_____

EMAIL: _____PREFERRED LANGUAGE_____

MARITAL STATUS: _____RACE/ETHNICITY_____

EMERGENCY CONTACT: _____RELATIONSHIP:_____

PRIMARY NUMBER:_____SECONDARY NUMBER_____

PRIMARY PHYSICIAN:_____PHONE NUMBER:_____

REFERRING PHYSICIAN_____PHONE NUMBER:_____

DO YOU SEE ANY OTHER SPECIALISTS? IF SO, PLEASE LIST CONTACT INFORMATION:_____

_____

EMPLOYERS NAME:_____OCCUPATION:_____

INSURANCE INFORMATION

Insurance Card (s) or proof of insurance must be presented at time of service

PRIMARY INSURANCE:_____POLICY NUMBER:_____

GROUP NUMBER:_____INSURED NAME:_____

RELATIONSHIP TO THE INSURED: _____DOB OF INSURED:_____

SECONDARY INSURANCE:_____POLICY NUMBER:_____

GROUP NUMBER:_____INSURED NAME:_____

RELATIONSHIP TO THE INSURED: _____DOB OF INSURED:_____

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PATIENT CONSENT FORM

General Consent for Care and Treatment

TO THE PATIENT: You have the right as a Patient to be recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision weather to undergo any suggested treatment or procedure after knowing the risk and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure or any identified condition (s). The consent will remain fully effective until it is revoked in writing.

This consent provides us with your permission reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. And (2) you consent to treatment at this office or any other satellite office under common ownership. You have the right to discuss the treatment plan with a physician about the purpose, potential risks and benefits of any tests ordered for you. If you have any concerns regarding any tests or treatment recommended by your healthcare provider, we encourage you to asks questions. You have the right at any time to discontinue services. I voluntarily request Dr. Greg Messner and or other healthcare provider or designees as deemed necessary to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought to me to seek care at Messner Vascular Institute. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s)

I acknowledge that I have read and fully understand the above statements and consents to fully and voluntarily to its contents..

PRINT NAME: _____

SIGNATURE OF PATIENT: _____

DATE: _____

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PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

PATIENT NAME:_____DATE OF BIRTH:_____

Notice of Privacy Practices

I acknowledge that I have received the Practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare Information for its treatment, payment healthcare operations, and other described and permitted uses and disclosures. I understand that this Information may be disclosed electronically by the provider and/or the provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practices.

Release of information

I hereby permit practice and the physicians or other health professionals Involved in the impatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other MVI affiliated facilities may be made available to subsequent MVI affiliated facilities to coordinate patient care for the case management purposes. Healthcare information may release to any person or entity liable for payment on the Patient's behalf to verify coverage or payment questions, or for any other purpose related to the benefits payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare Information to the Social Security Administration or its Intermediaries or carries for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may Include, without limitation, history and physical emergency records, laboratory reports, drug and alcohol treatment and discharge summary.

- Federal and State laws may permit this facility to participate in organizations with other healthcare providers, Insurers, and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy of and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my Information for quality improvement purposes and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions, and or infectious diseases including but not. limited to, blood borne diseases such as HIV and AIDS.

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Assignment and Authorization of Benefits for Patients with Insurance

I hear by assign all medical and/or surgical benefits to which I am entitle, including Medicare private insurance, and other plans to Messner Vascular Institute. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payments and to obtain reimbursement, I authorize disclosure of portions of the patient's medical records. I authorize insurance claims filed and benefits assigned.

Financial Acknowledgment for Private Pay Patients or Patients Without Insurance.

Patients who do not have insurance coverage are expected to pay charges in full at the time of services are rendered. I agree that I am financially responsible for all charges incurred at the time of service.

Our HIPAA acknowledgement form provides information about how we may use and disclose protected health information about you. You have the right to review our form before signing this consent. As outlined in our form, the terms of our term may change. If our form is changed or modified, you may obtain a revised copy by requesting from the receptionist. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare options. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

PATIENT SIGNATURE: _____

PRINT FULL NAME: _____

DATE: _____

LEGALLY AUTHORIZED INDIVIDUAL SIGNATURE:

_____

WITNESS SIGNATURE: _____

DATE: _____

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Do you want to designate a family member or other individual with whom you the provider may discuss your medical condition? If yes, please list who you would like to include below.

I give permission for my protected healthcare information to be disclosed for the purpose of communicating results and care decisions to the family member and others below:

NAME	RELATIONSHIP	CONTACT NUMBER

Patient may revoke or modify this specific authorization and that revocation or modification

Consent for Communicating Patient Health Information by Voicemail

_____(Patient Initials) I do consent to Messner Vascular Institute to leave voicemail with my health information if applicable.

_____(Patient Initials) I do NOT consent to Messner Vascular Institute to leave a voicemail with my health information if applicable.

Consent for Photographing or other Recording for Security or Health Care Operations

_____(Patient Initials) I do consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's healthcare operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the Images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these Images and/or recordings will be securely stored and protected. Images and/or recordings in which I identified will not be released and/or used without a specific written authorization from or my legal representative unless it is for treatment, payment, or healthcare operations purposes or otherwise permitted or required by law.

_____(Patient Initials) I do NOT consent to photographs, videotapes, digital or audio recordings and/or images of me being recorded for security purposes and/or the practice's Healthcare operations purposes.

PATIENT SIGNATURE:_____

PRINT PATIENT NAME:_____DATE:_____

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MEDICATION LIST

PATIENT NAME:_____DOB:_____

Please include all prescription & over the counter medications including herbal products and vitamins.

MEDICATION	DOSE	QUANTITY/FREQUENCY

PHARMACY NAME:_____

PHARMACY ADDRESS:_____

CITY/STATE/ZIP CODE:_____

PHONE NUMBER:_____FAX NUMBER:_____

PATIENT NAME:_____

PATIENT SIGNATURE:_____

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PAST MEDICAL HISTORY - CHECK ALL THAT APPLY

_____AORTIC ANEURYSM
_____ALZHEIMER/DEMENTIA
_____ANEMIA
_____ANGINA
_____ARRHYTHMIA [i.e: A-fib]
_____ASTHMA
_____CARDIOMYOPATHY
_____ANXIETY/PANIC ATTACKS
_____ARTHRITIS
_____STROKE/TIA
_____COPD/EMPHYSEMA
_____SLEEP APNEA
_____HEART FAILURE
_____CLOTTING/BLEEDING DISORDER
_____CORONARY ARTERY DISEASE
_____DIABETES
_____HEART MURMUR
_____HIGH BLOOD PRESSURE
_____DEPRESSION
_____VARICOSE/SPIDER VEINS
_____BRONCHITIS/PNEUMONIA
_____HIV/AIDS
_____MENOPAUSE
_____OTHER_____
_____KIDNEY DISEASE STAGE
_____HEART ATTACK WHEN:_____
_____PERIPHERAL ARTERY DISEASE
_____CIRROHOSIS/HEPATITIS TYPE____
_____BLOOD CLOTS IN VEINS/LUNGS
_____THYROID DISEASE
_____EPILEPSY/SEIZURES
_____PHLEBITIS/SWELLING/CELLULITIS
_____RHEUMATIC FEVER
_____ACID REFLUX/STOMACH ULCERS
_____TUBERCULOSIS

SURGICAL HISTORY - CHECK ALL THAT APPLY:

_____APPENDECTOMY
_____CARPAL TUNNEL SYNDROME
_____CATARACT/GLAUCOMA
_____C-SECTION
_____CABG
_____CARDIAC/VASCULAR STENT
_____IVC FILTER
_____FRACTURE REPAIR
_____GALL BLADDER
_____HIP REPLACEMENT
_____HYSTERECTOMY/TUBAL LIGATION
_____PACEMAKER/AICD
_____CAROTID ARTERY REPAIR
_____HERNIA REPAIR
_____KNEE REPLACEMENT
_____BLOOD TRANSFUSION
_____TONSILS/ADENOIDS
_____BACK/NECK
_____HEART VALVE REPLACEMENT
_____GASTRIC BYPASS
_____OTHER_____

_____

PAST HOSPITALIZATIONS:_____

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CONFIDENTIAL HEALTH INFORMATION

NAME:_____DATE:_____

REASON FOR YOUR VISIT:_____

DESCRIBE YOUR SYMPTOMS:_____

WHEN DID THEY START:_____

HOW LONG DOES IT LAST?_____

FAMILY MEDICAL HISTORY (CHECK IF YES)

FATHER:	____LIVING?	____HEART DISEASE?	____STROKE?	____OTHER?
MOTHER:	____LIVING?	____HEART DISEASE?	____STROKE?	____OTHER?
GRANDFATHER:	____LIVING?	____HEART DISEASE?	____STROKE?	____OTHER?
GRANDMOTHER:	____LIVING?	____HEART DISEASE?	____STROKE?	____OTHER?
BROTHER/SISTER:	____LIVING?	____HEART DISEASE?	____STROKE?	____OTHER?

SOCIAL HISTORY

TOBACCO USE: ____NEVER ____QUIT DATE: _____

DO YOU SMOKE: ____PIPE ____CIGAR ____CIGARETTE ____CHEWING TOBACCO ____E-CIGARETTE

IF YOU ARE A SMOKER, HOW MANY PACKS/DAY:_____

DO YOU DRINK ALCOHOL? ____YES ____FORMERLY ____NEVER

TYPE ____BEER ____WINE ____LIQUOR

HOW OFTEN? (DRINKS/DAY) _____

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____YES ____NO

IF YES, PLEASE LIST:_____

HAVE YOU HAD A REACTION TO X-RAY CONTRACT DYE _____YES ____NO

ARE YOU ALLERGIC TO IODINE OR SHELLFISH? _____YES ____NO

ARE YOU ALLERGIC TO LATEX? _____YES ____NO

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NAME:_____DOB_____

SYMPTOMS

DO YOU EXPERIENCE ANY OF THE FOLLOWING IN YOUR LEGS?	NO	LEFT	RIGHT	WORST? COMMENTS (OPTIONAL)
ACHING/PAIN				
HEAVINESS				
TIREDNESS/FATIGUE				
ITCHING/BURNING				
SWOLLEN ANKLES				
LEG CRAMPS				
RESTLESS LEGS				
THROBBING				
OTHER				

Your quality of life would be better if what changed with your legs?_____

How many years have you had varicose veins? (circle) 1 2 3+ 5+ 10+ 15+ 20+

What is the pain level in your legs? (circle one)

PAIN RATING SCALE (LOWER EXTREMITY)

HAVE YOU EVER HAD THE FOLLOWING?	NO	LEFT	RIGHT	COMMENTS (OPTIONAL)
VEIN STRIPPING				
VEIN INJECTIONS				
LEG ULCERATIONS				
BLOOD CLOTS				
PHLEBITIS				
PERIPHERAL ARTERY DISEASE				

*Activities of Daily Living - Because of your legs, what do you have the most trouble with?

☐ Preparing Meals ☐ Standing ☐ Stairs ☐ Work ☐ Going to store Other_____

*Do you have a family history of varicose veins? ☐ No ☐ Yes Who?_____

*Do you wear/have you worn compression stockings? ☐ No ☐ Yes How long?_____

*Have your symptoms/worsened in recent months? ☐ No ☐ Yes

*Do you elevate your legs for discomfort? ☐ No ☐ Yes How long?_____

*Do you undergo exercise like walking/strengthening? ☐ No ☐ Yes How often?_____

*Do you take any medications for your leg discomfort including ☐ No ☐ Yes List Medication_____

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LOWER EXTREMITY FUNCTIONAL SCALE (LEFS)

Common leg symptoms related to Chronic Venous Insufficiency (CVI) are:
aching/pain in legs, heaviness, tiredness, fatigue, itching/burning, swollen ankles, leg cramps, restless legs, throbbing

Please circle the number that best describes your current ability

	EXTREME DIFFICULTY OR UNABLE TO PERFORM ACTIVITY	QUITE A BIT OF DIFFICULTY	MODERATE DIFFICULTY	A LITTLE BIT OF DIFFICULTY	NO DIFFICULTY
1. Ability to stand or sit for long periods of time at work or home.	4	3	2	1	0
2. Ability to walk moderate distances due to leg symptores.	4	3	2	1	0
3. Ability to drive more than 1 hour due to leg symptoms.	4	3	2	1	0
4. Ability to perform work functions. Specify in own words:	4	3	2	1	0
5. Ability to perform home functions. Specify in own words:	4	3	2	1	0
6. Ability to get uninterrupted sleep, or difficulty falling to sleep due to leg symptoms.	4	3	2	1	0