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LASER AND VEIN ESTHETICS

DATE_____

NAME_____ SEX: M_____F____
BIRTHDATE_____

CURRENT CONDITION RELATED TO TODAY'S APPOINTMENT:
_____

ASSOCIATED SYMPTOMS: _____

WHAT MEDICAL PROBLEMS HAVE YOU HAD IN THE PAST, OTHER THAN WHAT YOU ARE SEEING THE DOCTOR TODAY? THESE MAY BE ACTIVE OR NOT BOTHERING YOU NOW; SOME EXAMPLES: CANCER, COLON PROBLEMS, PNEUMONIA, BRONCHITIS, DEPRESSION, MIGRAINES, etc. _____

_____

PAST SURGICAL HISTORY:_____

_____

NAME OF PHYSICIAN WHO REFERRED YOU_____

HAVE YOU EVER HAD OR ARE YOU NOW EXPERIENCING ANY OF THE FOLLOWING CONDITIONS? (PLEASE CHECK IF YES)

HIGH BLOOD PRESSURE_____ **HEPATITIS_____**

DIABETES_____ **ULCER DISEASE_____**

HEART PROBLEMS_____ **VASCULAR DISEASE_____**

CANCER_____ **BLOOD CLOTS_____**

HIV_____

ARE YOU TAKING ANY MEDICATIONS NOW? YES_____ NO_____ IF YES, PLEASE LIST THEM
_____

_____

DO YOU HAVE ANY ALLERGIES TO MEDICINES? YES_____ NO_____ IF YES, PLEASE LIST THEM:

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SOCIAL AND FAMILY HISTORY:

DO YOU SMOKE? YES_____ NO_____ HOW MANY PACKS A DAY? _____
DO YOU DRINK? YES _____ NO_____ HOW MUCH OR HOW FREQUENT?_____

HAS ANYONE IN YOUR FAMILY (MOTHER, FATHER, BROTHERS, SISTERS, GRANDMOTHERS, GRANDFATHERS) EVER HAD ANY OF THE FOLLOWING CONDITIONS? PUT A CHECK NEXT TO EACH.

HIGH BLOOD PRESSURE_____ **VARICOSE VEINS_____**

DIABETES_____ **CANCER_____**

HEART PROBLEMS _____

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Name: _____

Please circle all that apply:

1. Do you take any of the following on a regular basis?
   Oral contraceptives Premarin Aspirin Steroids Digoxin
2. Are you allergic to: Iodine Local anesthetics (Xylocaine) Tape
3. Do you have a family history of varicose veins or spider veins? Yes No
   If yes, please list the relatives who have them: _____
4. How many years have you had varicose or spider veins? _____
5. Did you first notice these veins: after an accident/trauma before pregnancy
   After or during pregnancy after taking hormones or oral contraceptives
6. Are you required to be on your feet for long periods of time? Yes No
7. Are you developing new veins? YES NO
8. Do you bruise easily? Yes No
9. Have you had any previous bypass surgery? Yes No
10. Do you have: excessive bleeding bleeding disorder dizziness
    transient vision loss transient weakness of limbs
11. Do you now have or have you had:

unsightly veins	right	left
Aches or pains	right	left
Heaviness or tired legs	right	left
Ankle edema or swelling	right	left
Itching	right	left
Night cramps	right	left
Bleeding from veins	right	left
Discoloration of legs	right	left
Dermatitis (eczema)	right	left
Ulceration	right	left

12. Do you have a previous history of:

Superficial phlebitis	right	left
Deep thrombophlebitis	right	left
Pulmonary emboli	right	left

13. Have you had treatments of:

Compression stockings	right	left
Length of time worn	_____	
Compression grade (mmHg)	15-20	20-30
	30-40	40-50
Ligation	right	left
Vein stripping	right	left
Local excision	right	left
Cautery	right	left
Sclerotherapy	right	left

14. Do you have leg pains while walking in the:

foot	right	left
Calf	right	left
Thigh	right	left
Buttock	right	left

15. Do you have leg pains while resting in the:

foot	right	left
Calf	right	left

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PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security: _____

Effective April 14, 2003, the federal government set a law in place to protect you and the release of your medical information whether it be in written or oral form. Our office is permitted by law not to release protected health information outside of treatment, payment, and healthcare operations without your written consent.

Please list the people (including family members) or companies in which you wish the office of David Vanderpool, M.D. to release your medical records.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates of treatment: _____

_____

All Healthcare information

I hereby authorize the office of David Vanderpool M.D. to release my protected health information to the above people listed. I understand I have the right go revoke this consent at anytime in writing. I am also aware that this consent is binding and will expire two years from the date of signature.

_____ _____

Patient's signature Date of Signature

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LASER AND VEIN ESTHETICS

PATIENT INFORMATION

Today's Date_____/_____/_____

Last Name:_____ First Name: _____ Middle:_____

Address:_____

City:_____ State:_____ Zip:_____

E-Mail Address_____

Home phone: _____ _____ _____ Work phone: _____ _____ _____ Cell phone:____ ____ _____

Date of Birth_____/_____/_____ Social Security:_____/_____/_____

Marital Status: _____Married _____Single ____Divorced ____Widowed

How did you hear about us? _____

My Insurance is Covered Through: _____Employer _____Self _____Spouse _____Other

IF YOUR INSURANCE COVERAGE IS UNDER ANOTHER PERSON'S PLAN, PLEASE COMPLETE THE FOLLOWING:

Name of insured_____

Date of Birth:_____/_____/_____ Social Security_____/_____/_____

INSURANCE AUTHORIZATION:

I hereby authorize my insurance benefits to be paid directly to David Vanderpool, M.D. I realize I am responsible for any fees not covered by my insurance policies. I also authorize the release of pertinent medical information to my insurance carriers.

Patient Signature_____Date:_____

Patient Rights

Effective April 14, 2003: The Federal Government set a law in place to protect you and the release of your medical information. We, at Dr. Vanderpool's Office, promise to do our part in upholding this law. Our office is permitted by federal laws to make uses and disclosures of your health information for purposes of treatment, payment, and healthcare operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examinations, test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

A Copy of the Federal Privacy Law is available to you at your request

___Yes, I would like a copy of the Federal Privacy Law ___ No, I would not like a copy of the Federal Privacy Law
I have read about information regarding the Federal Privacy Law and understand my rights as a patient at this office.

Patient Signature: _____ Date: _____

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PATIENT INFORMATION UPDATE

Today's Date: _____/ _____ / _____ **DOB**: _____/ _____ / _____

Last Name _____ **First Name** _____ **MI** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home: (_____) _____ **Work:** (_____)-_____ **Cell:** (_____) _____

Social Security: _____/_____/_____ **E-mail:** _____

Emergency Contact: _____ (_____) _____

Has there been a change in your insurance? ❑ YES ❑ NO

Please put a check mark next to the procedures about which you would like to receive more information:

- ❑ BOTOX® Cosmetic
- ❑ Restylane /Juvaderm
- ❑ Collagen Stimulation
- ❑ Collagen Replacement
- ❑ Fine Lines
- ❑ Deep Lines and Wrinkles
- ❑ Age Spots
- ❑ Brown Spots / Sun Damage
- ❑ Liver Spots / Sun Spots
- ❑ Birthmarks
- ❑ Melasma / Pregnancy Mask
- ❑ Rosacea / Facial Redness
- ❑ Facial veins / Broken Capillaries
- ❑ Micro-Dermabrasion
- ❑ Chemical Peels
- ❑ Sagging / lax skin
- ❑ Skin Rejuvenation
- ❑ Photo aged skin
- ❑ Pore appearance
- ❑ Skin tone and texture
- ❑ Avage™, Retin-A or Renova
- ❑ Acne
- ❑ Acne Scars
- ❑ Other, please specify _____
- ❑ Skin Care Advice
- ❑ Skin Care Products
- ❑ Skin exfoliation
- ❑ Make up
- ❑ Sunscreen Advice
- ❑ Facials
- ❑ Eye Treatments
- ❑ Dry Skin
- ❑ Oily Skin
- ❑ Combination Skin
- ❑ Laser Treatments
- ❑ Laser Resurfacing
- ❑ Tattoo removal
- ❑ Removing Leg Veins
- ❑ Spider Vein Treatments
- ❑ Laser Hair Removal
- ❑ Massage Therapy
- ❑ Triactive/ Cellulite Treatment
- ❑ Ingrown Hair / Shaving Bumps
- ❑ Laser Hair Removal
- ❑ Waxing