InvisiVein

These forms can be filled out and printed or printed and filled out by hand.

INVISIVEIN INFORMATION SHEET

Patient Name:_____ M/F Phone:_____
Work Phone:_____ Cell Phone:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Age:_____ DOB: _____ S.S. Number:_____
E-Mail Address:_____
Emergency Contact:_____ Phone:_____
Marital Status: ◯M ◯S ◯D ◯W
Diabetes Y/N ◯◯ Heart Condition Y/N ◯◯ Circulatory Problems Y/N ◯◯

Referring Physician:_____ Phone:_____

How did you hear about Invisivein?_____

Immuno-Compromised	◯ Y/N ◯	
Coumadin Therapy	◯ Y/N ◯	
Aspirin Therapy	◯ Y/N ◯	
Recent Surgery	◯ Y/N ◯	If Yes, when _____ what type of Surgery
Pregnancy	◯ Y/N ◯	
Nursing	◯ Y/N ◯	
Phlebitis	◯ Y/N ◯	
History of blood clots	◯ Y/N ◯	
Hepatitis	◯ Y/N ◯	
AIDS/ HIV	◯ Y/N ◯	

The above information is correct and factual to the best of my knowledge.

Patient Signature_____ **Date**: _____

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INSURANCE INFORMATION

Primary Insurance

Name of Insurance_____

Policy Holder's Name _____

Date of Birth_____

Relationship to Patient_____

Secondary Insurance

Name of Insurance_____

Policy Holder's Name_____

Date of Birth_____

Relationship to Patient_____

Additional Insurance

Name of Insurance_____

Policy Holder's Name_____

Date of Birth_____

Relationship to Patient_____

Patient Signature _____ Date _____

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Patient Health History Form

Name_____**Date of Birth**_____
Occupation_____
Referred by:_____
Directions: Please answer the following questions, trying not to leave any blank spaces.

Medical History

Do you have any of the following?

	Yes	No		Yes	No
High blood pressure	○	○			
Heart Disease	○	○			
Cardiac Pacemaker	○	○	Cancer	○	○
Heart Murmur	○	○	Hepatitis	○	○
Liver Disease	○	○	Hay Fever	○	○
Mitral Valve Prolapse	○	○	Stroke	○	○
Artificial Joints	○	○	Allergies	○	○
Diabetes	○	○	HIV Infection	○	○
Keloids/excessive scar	○	○			
Do you need antibiotics before surgical or dental treatments				○	○

Please list any other medical problems or surgeries and explain any of the above "yes" answers if needed.

_____
_____

Do you have any allergies?_____
If yes, please list specific allergies (such as: medications, latex or seasonal allergies)

_____
_____

Family Medical History

Please list the history of disease/illness (such as: diabetes, heart diease, stroke, cancer, gall & kidney stones, arthritis, etc...) for these immediate family members: mother, father, brothers, sisters.

Mother _____
Father _____
Brothers _____
Sisters _____

Vein History

1. Please circle any that apply:
   Aching/pain in your legs/ Heaviness/Tiredness/fatigue/Itching/burning/
   Swollen ankles/ Leg cramps/Restless legs/ Throbbing
   Other_____
2. Have your veins become worse in the past 6 months? .....Yes ◯ No ◯
3. Do you elevate your legs to relieve discomfort? .....Yes ◯ No ◯
4. Have you ever (in your life) worn compression
   stockings recommended by a medical professional…… Yes ◯ No ◯
   If yes, what type and how long?_____
5. Does your vein problem affect your everyday life activities…….Yes ◯ No ◯
6. Have you ever had your veins evaluated before? .....… Yes ◯ No ◯
   If yes, when and where?_____
7. Have you had any tests done on your veins? .....Yes ◯ No ◯
8. Does anyone in your family have varicose veins?..... Yes ◯ No ◯

Current Medications_____

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Women Only

1. Do you think you are presently pregnant? .....Yes ◯ No ◯
2. How many times have you been pregnant?_____
3. Do you intend on having any more children?.....Yes ◯ No ◯
4. Are you presently breastfeeding?.....Yes ◯ No ◯
5. Are you taking oral contraceptives? .....Yes ◯ No ◯
6. Are you taking hormone replacement?.....Yes ◯ No ◯

The above information is correct and factual to the best of my knowledge.

Patient's Signature_____ Date: _____

InvisiVein
1241 Woodland Avenue
Mt. Pleasant, SC 29464
(843) 824-6453

Authorization and Release Form

- I hereby authorize my referring physician to release all medical information necessary to complete my medical care
- I hereby authorize the release of all medical information necessary to process this claim
- I hereby authorized payment of medical benefits directly to the physician or supplier of services on said claim
- I understand that fees are subject to change based on actual exam(s)
- I understand that I am responsible for any charges or charge balances not paid by my insurance and agree to pay these amounts
- I understand that in the event legal action should become necessary to collect an unpaid balance due for medical services rendered, I agree to pay for reasonable attorney fees or other such costs as the court determines proper

As a courtesy, please give our office at least 48 hours notice to cancel or reschedule an appointment. This gives us a chance to provide care to another patient who may be waiting for an earlier appointment time. When an appointment is broken without the required 48-hour notice, there will be a charge of $75.00.

_____ _____
Patient/Responsible Party Date

_____ _____
Witness Date

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MEDICAL PHOTOGRAPHY CONSENT FORM

PATIENT CONSENT

I, _____

FIRST NAME LAST NAME DOB

Consent to medical images and/or videos being made of me or my child/dependant. I agree that duplicates may be made for the referring doctor and insurance company.

I agree that the images may be: (check all that apply)	YES	NO
…place in my medical record for future treatment and submitted to my insurance provider	_____	_____
…used by health professionals for education/training	_____	_____

By signing below, I confirm that I understand this consent form.

_____ _____

Signature of Patient/Parent or Guardian Date

_____ _____

Signature of Witness Date