

MEDICAL INFORMATION

Patient Name _____ D.O.B. ___/___/___

Hgt _____ Wgt _____ lbs Pulse _____ B/P _____

Allergies _____

- Latex Sulfa Local Anesthetics

Smoke Tobacco? Yes No Packs/day _____ Number of Years _____

Have you ever had a Pelvic, Hip or Leg fracture?..... Yes No

If yes what/when? _____

Have you had surgery within the last six months? Yes No

If yes what surgery? _____

Ever had Hysterectomy Heart Surgery Angiogram

Do you require antibiotics before surgery or dental work?.. Yes No

Do you get short of Breath walking up one flight of stairs? Yes No

Are you now or have you ever been treated for any of the Medical conditions listed below? (Please check all that apply)

- | | | | |
|--|------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Heart Disaese | <input type="checkbox"/> Cancer | <input type="checkbox"/> Lupus | <input type="checkbox"/> Asthma/COPD |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure | <input type="checkbox"/> Eczema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psoriasis | |

Are you currently taking any of the Medications Listed below? (Please check all that apply)

- | | | | | |
|-----------------------------------|-----------------------------------|-------------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> Coumadin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Insulin | <input type="checkbox"/> Requip | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Plavix | <input type="checkbox"/> Dilantin | <input type="checkbox"/> Prednisone | <input type="checkbox"/> Valium | <input type="checkbox"/> Xanax |
-

Patient Venous History

Patient Name _____ D.O.B. ____/____/____

Do you have any of the following symptoms in your legs (please check all that apply)

Symptom	Right	Left	Both
---------	-------	------	------

Pain/Aching

Swelling/Edema

Cramping

Restlessness

How long have you had these symptoms? _____

Are the symptoms getting worse or more frequent? Yes No

Are your symptoms worse at the end of the day?..... Yes No

Does elevating your legs make the symptoms better? Yes No

Have you taken Aspirin/Tylenol/Motrin/Advil for symptoms in your legs? Yes No

Have you ever had/or been treated for an ulcer on either leg Yes No

Which Leg _____ When _____

Do you have or have you ever been treated for Restless Leg Syndrome? Yes No

Have you ever worn support hose Yes No How long? _____

Did wearing support hose make your legs feel better?..... Yes No

Have you ever had or been treated for a blood clot in your leg? Yes No

If Yes When? _____ Was a filter placed? Yes No

PATIENT VENOUS HISTORY CONTINUED

PATIENT NAME _____

D.O.B. _____

Do you stand for long periods of time during the day? Yes No

Does anyone in your family have varicose/spider veins?..... Yes No

If Yes Who? _____

Does any one in your family have a history of blood clots?..... Yes No

If Yes Who? _____

Have you had any prior treatment for Varicose/spider veins? ... Yes No

What type of treatment? Vein Stripping Injection

Which Leg? Right Left Both When? _____

Have you ever been pregnant? Yes No

Were there any problems related to the pregnancy..... Yes No

If Yes What Problems _____

Did you first notice Varicose veins during or after pregnancy? Yes No

Are you pregnant now or do you plan to become pregnant in the near future Yes No

Are you taking Estrogen/Progesterone/Birth Control Pills now Yes No

CONDITIONS OF SERVICE

Patient Name _____ D.O.B. ____/____/____

Thank you for choosing Southern Illinois Vein Center for your care. The following are our established conditions of services that will be followed in resolving all issues for services rendered by our staff.

CONSENT TO TREATMENT

The patient consents to the examinations, treatments and procedures while under the care of Dr. Robelen and/or his staff, which may include but are not limited to medical/surgical examinations and treatments, venous ultrasound, sclerotherapy and/or tumescent anesthesia under the general and special instructions of the patient's physician or surgeon.

PRIVATE PAY

For patients having no insurance or choosing not to bill their insurance it is expected that all services will be paid in full at the time of service. For your convenience we will accept cash, check or credit card for payment.

ASSIGNMENT OF INSURANCE

We have made arrangements with a few insurers and health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement. You will be required to pay the deductible and/or co-payment at the time of service.

I, the undersigned, represent that I have insurance coverage with and hereby authorize my insurance company to pay and assign directly to James V. Robelen MD, FACS, dba Southern Illinois Vein Center, all surgical and/or medical benefits, if any, otherwise payable to me for services at a rate not to exceed Southern Illinois Ven Center's regular charges for those services.

If you have insurance coverage with a plan we do not have a prior agreement with, then we will assist you in your claim to your insurance carrier. You will be responsible, however, for payment in full at the time of service unless other arrangements have been made prior to service.

MEDICARE

Southern Illinois Vein Center does accept Medicare. You will be required to pay the deductible at the time of service unless this is covered by any supplemental insurance you may have.

I, the undersigned, certify that all the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges of the physician charges for his services. I understand I am responsible for any remaining balances.

CONSENT TO PHOTOGRAPH and/or VIDEOTAPING

Southern Illinois Vein Center is permitted to take pictures and/or video of the patient before, during or after treatment in order to document extent of disease, treatment and/or response to treatment involving the patient and to use the same for scientific, educational or research purposes.

PERSONAL VALUABLES

It is understood and agreed that Southern Illinois Vein Center shall not be liable for the loss or damage to any money, jewelry, documents, garments, dentures, eye glasses, hearing aids, prosthetics or other articles of unusual value and small size and shall not be liable for loss or damage to any other personal property.

RELEASE OF INFORMATION

In accordance with HIPAA regulations, Southern Illinois Vein Center will obtain the patient's consent and authorization prior to release of patient's protected health information. Further information will be found in the attached "Notice of Privacy Practices".

Patient's Signature

Date