THE VEIN CENTER

TODAY'S DATE:_____

PATIENT INFORMATION:

LAST NAME:_____**FIRST NAME:**_____

SEX: M F DOB:_____**AGE NOW:**_____**SSN:**_____/_____/_____

ADDRESS:_____**CITY:**_____**STATE:**_____**ZIP:**_____

HOME PHONE:_____**CELL PHONE:**_____

PLACE OF EMPLOYMENT:_____**WORK PHONE:**_____

CIVIL STATUS: MARRiED DIVORCED SINGLE WIDOWED OTHER

SPOUSE'S NAME:_____**IF MINOR, PARENT/GUARDIAN NAME:**_____

INSURANCE INFORMATION:

MEDICAREPOLICY#_____ **MEDICAIDPOLICY#**_____

INSURANCE COMPANY NAME:_____**POLICY#**_____**GROUP#**_____

INSURANCE COMPANY NAME:_____**POLICY#**_____**GROUP#**_____

CARDHOLDER INFORMATiON

LAST NAME:_____ **FIRST NAME**:_____ **M.I.**____

RELATIONSHIP:_____ **DOB:**_____**SSN:**_____/____/_____**SEX: M F**

ADDRESS:_____**CITY:**_____**STATE:**_____**ZIP:**_____

HOME PHONE:_____**CELL PHONE:**_____

PLACE OF EMPLOYMENT:_____

IN CASE OF EMERGENCY NOTIFY: (OTHER THAN SPOUSEII)

NAME:_____ **PHONE#**_____

ADDRESS:_____**RELATIONSHIP:**_____

NAME:_____ **PHONE#**_____

ADDRESS:_____**RELATIONSHIP:**_____

ALLERGIES TO MEDICATIONS:

_____

_____

_____

REQUIRED INFORMATION ON NEXT PAGE

MEDICAL HISTORY - REQUIRED

LIST ALL CURRENT MEDICATIONS, INCLUDING DOSAGE, STRENGTH, ETC.

1_____	8_____
2_____	9_____
3_____	10_____
4_____	11_____
5_____	12_____
6_____	13_____
7_____	14_____

DO YOU: SMOKE? YES NO **HOW MUCH DAILY?_____**

DRINK COFFEE? YES NO **HOW MUCH DAILY?_____**

DRINK ALCOHOL? YES NO **HOW MUCH?_____**

TAKE DIET MEDICATION? YES NO **FOR HOW LONG?_____**

IMMUNIZATIONS:	DATE:	DIAGNOSTIC PROCEDURFS	DATE
PNEUMONIA	_____	PAP SMEAR	_____
FLU VACCINE	_____	MAMMOGRAM	_____
TETANUS	_____	PROSTATE	_____
TB	_____	COLONOSCOPY	_____
		LAST COMPLETE PHYSICAL	_____

(IF CHILD, NEED COPY OF IMMUNiZATiON RECORD)

LIST HOSPITALIZATIONS AND SURGERIES:

1._____DATE:_____PHYSICIAN:_____

2._____DATE:_____PHYSICIAN:_____

3._____DATE:_____PHYSICIAN:_____

4._____DATE:_____PHYSICIAN:_____

5._____DATE:_____PHYSICIAN:_____

HEART DISEASE?	YES	NO	BLEEDING DISORDER?	YES	NO
HIGH BLOOD PRESSURE?	YES	NO	KIDNEY DISEASE?	YES	NO
CANCER?	YES	NO	THYROID DISEASE?	YES	NO
DIABETES?	YES	NO	OSTEOPOROSIS?	YES	NO
STROKE?	YES	NO	ASTHMA?	YES	NO
OTHER DISORDERS?	YES	NO	IF YES, PLEASE EXPLAIN:_____		

FAMILY HEALTH HISTORY

A. FATHER: IF LIVING, GIVE AGE_____HEALTH PROBLEMS?_____

IF DECEASED, AGE AT TIME OF DEATH_____CAUSE?_____

B. MOTHER: IF LIVING, GIVE AGE_____HEALTH PROBLEMS?_____

IF DECEASED, AGE AT TIME OF DEATH_____CAUSE?_____

C. BROTHERS AND SISTERS: TOTAL_____NUMBER LIVING?_____NUMBER DECEASED?_____

CAUSE?_____OTHER HEALTH PROBLEMS?_____

D. CHILDREN: TOTAL_____AGES:_____ILLNESSES?_____

The Vein Center

215 N. Avenue J
Anson, Texas 79501
(325) 668-8046

I hereby accept all medical treatment at The Vein Center, Abilene, Texas, as provided by the medical staff. I will read and follow all pre and post procedure instructions provided to me.

The Vein Center may disclose all or any part of the patient's records to any person(s) or company liable for all or part of the centers charges, included but not limited to Family Physician and Insurance companies.

It is further understood that The Vein Center will accept Medicare assignment. In the event the undersigned is entitled to benefits of any type, arising out of any insurance, insuring the patient or any other party liable to the patient, said benefits are hereby assigned to The Vein Center for application on the patient' s bill. It is agreed that The Vein Clinic will accept such receipt for any such payment towards the charges. The undersigned, and/or patient, is responsible for charges not covered or addressed by this assignment.

The undersigned certifies that he/she has read the foregoing, and is the patient, or is duly authorized by the patient as the patient's guardian to execute the above and accept its terms.

_____ _____

DATE PATIENT

_____ _____

WITNESS PATIENT SIGNATURE

_____

Relationship To Patient

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority