

VeinTherapies

Laser Skin and Vein Solutions
W. Clark Beckett, M.D., F.A.C.S.

3770 7th Terrace, Suite 102 • Vero Beach, Florida 32960 • 772.567.6602 • Fax 772.567.7754

Appointment Date: ____/____/____ **Time:** ____ **AM/PM**

Thank you for choosing **VeinTherapies**, Laser Skin and Vein Solutions. We appreciate the opportunity to provide you with a one-on-one individualized consultation to learn how we can help you look and feel years younger!

Enclosed please find a venous medical history and patient information form for your completion. Please bring these completed forms to your appointment.

We do participate with some of the major health insurance companies. Co-payments, deductibles and patient responsibility, as directed by your plan, will be collected at the time of service. We suggest that you call your insurance company for your benefits and policy requirements.

Compression stockings are not paid for by your insurance company. We accept cash, check, Visa and MasterCard as forms of payment.

Please note: insurance plans do not cover treatment for spider veins & cosmetic treatments; payment for these services will be collected at the time of your appointment.

If you have any questions regarding your appointment or our services please call our office and one of our friendly associates will gladly answer any questions you may have.

If you are unable to keep your appointment please call 48 hours in advance so that we may offer the time to another patient.

We look forward to meeting with you.

Sincerely,
Faith Shepherd
Business Manager

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DATE: _____

PATIENT EMAIL: _____
(to receive emails on our latest laser information)

How did you hear about our office? (circle one) Friend Press Journal Physician VB Magazine
Other _____

SECTION A: PATIENT INFORMATION

NAME: LAST _____ FIRST _____ INITIAL _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ DATE OF BIRTH _____

SECONDARY ADDRESS _____

CITY _____ ST _____ ZIP _____ PHONE _____

PATIENT SOCIAL SECURITY # _____ MARITAL STATUS _____

PERSON RESPONSIBLE FOR BILL _____ REFERRED BY _____

EMPLOYER _____ OCCUPATION _____

STREET ADDRESS _____ CITY _____ ST _____ ZIP _____

PHONE # _____

SECTION B: SPOUSE INFORMATION

NAME _____ DATE OF BIRTH _____ SOC.SEC.# _____

EMPLOYER _____ OCCUPATION _____

STREET ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

SECTION C: IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME _____ RELATIONSHIP _____ PHONE _____

RELATIVE _____ RELATIONSHIP _____ PHONE _____

SECTION D: (circle answer)

Is Medicare your Primary? YES NO Is your Medicare a PFFS, PPO or HMO MC? YES NO

Do you have Medicare Part B? YES NO

SECTION E: **If insurance cards are copied skip this section**

PRIMARY INSURANCE

INS.CO.NAME _____

INSURED _____ RELATIONSHIP _____

ID# _____ GROUP# _____

SECONDARY INSURANCE

INS.CO.NAME _____

INSURED _____ RELATIONSHIP _____

ID# _____ GROUP# _____

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VEIN PATIENT HISTORY FORM

Name _____ D.O.B. _____

Date of visit _____ Telephone(H) _____ (C) _____ Age _____

Referring Physician _____

Chief Complaint _____

Prior Vein Treatment No _____ Yes _____ Explain _____

(Nurse will record BP) Blood Pressure Left _____ Right _____ Pulse _____

PERSONAL HABITS:

1. Tobacco Use: No _____ Yes _____ How Much _____ Quit _____ How Long Ago _____

2. Alcohol Use: No _____ Yes _____ How Much _____ Quit _____ How Long Ago _____

3. Caffeine Use: No _____ Yes _____ How Much _____ Quit _____ How Long Ago _____

4. Exercise Program: No _____ Yes _____ Describe: _____

5. Nursing Mother: No _____ Yes _____

GENERAL INFORMATION:

1. Allergies: _____

2. Current Medications:

3. Surgeries: (Include Dates)

(Nurse will record) Stocking Size: _____ Ankle _____ Calf _____ Thigh _____ Length _____

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MEDICAL HISTORY: (Please check all that apply)

GENERAL:	Yes	No	RESPIRATORY:	Yes	No
Headaches	_____	_____	Difficulty Breathing	_____	_____
Dizziness	_____	_____	Chronic Cough	_____	_____
Blurred/Double Vision	_____	_____	Asthma	_____	_____
Cataracts	_____	_____	Emphysema	_____	_____
Dentures	_____	_____			
NEUROLOGICAL:			DIGESTIVE:		
Seizures	_____	_____	Heart Burn	_____	_____
Paralysis	_____	_____	Nausea/Vomiting	_____	_____
Tremors	_____	_____	Constipation	_____	_____
TIA's	_____	_____	Ulcer Disease	_____	_____
Stroke	_____	_____			
Parkinson's	_____	_____	KIDNEY/BLADDER:		
Alzheimer's	_____	_____	Frequent Urination	_____	_____
			Incontinence	_____	_____
CARDIOVASCULAR:			Difficulty Urination	_____	_____
Chest Pain	_____	_____	Kidney Disease	_____	_____
Murmur	_____	_____			
High Blood Pressure	_____	_____	MUSCLES/BONES/JOINTS:		
High Cholesterol	_____	_____	Back Pain	_____	_____
Irregular Heart Beat	_____	_____	Muscle Weakness	_____	_____
Congestive Heart Failure	_____	_____	Arthritis	_____	_____
Heart Attack	_____	_____	Osteoporosis	_____	_____
Pacemaker	_____	_____			
PVS:			HEMAT/LYMPH/IMMUNO:		
Varicose Veins	_____	_____	Anemia	_____	_____
Spider Veins	_____	_____	Bleeding Tendency	_____	_____
Leg Pain-----at rest	_____	_____	Hepatitis, Type _____	_____	_____
Walking	_____	_____	Cancer, Type _____	_____	_____
Deep Vein Clot	_____	_____	Peripheral Neuropathy	_____	_____
Superficial Phlebitis	_____	_____	Liver Disease	_____	_____
			Diabetes, Type _____	_____	_____

Do you have any other Health care concerns not mentioned previously _____

Patient Name: _____ DOB: _____