VEIN & SURGERY CENTER

Name (Last, First, Middle)		Soc.Sec.Number	Birth Date	Sex
Local Address		City State Zip		
Secondary/ Billing Address - (If Applicable)		City State Zip		
Home Phone	Cell Phone	Email		
Race/Ethnicity	Languages	Work Phone	Occupation	
Employer Name (□Retired/□Disabled/□None)		Employer Address City State Zip		
Referred By? □Physician↓ □Self-Referred→		How did you hear about TVS?		
Referring Physician - Name & Specialty:		Office Address City State Zip		
Emergency Contact Name	Relationship	Best Contact Phone	Email	

Responsible Party Information - (Please complete if different than patient information above)

Name (Last, First, Middle)		Soc.Sec.Number	Birth Date	Sex
Local Address		City State Zip		
Secondary/ Billing Address - (If Applicable)		City State Zip		
Home Phone	Work Phone	Relationship to Patient: □Self □Spouse □Parent □Guardian □Other		

Primary Insurance

Name of Insurance Company	Policy#	
Policy Holder-Name of Insured	Group#	
Insurance Through Employer? (If yes, Employer Name and Address)	Copay Amount	
City State Zip	Deductible	
Relationship to Patient: □Self □Spouse □Parent □Guardian □Other	Effective Date	Expiration Date

Secondary Insurance - (If Applicable)

Name of Insurance Company	Policy#	
Policy Holder-Name of Insured	Group#	
Insurance Through Employer? (If yes, Employer Name and Address)	Copay Amount	
City State Zip	Deductible	
Relationship to Patient: □Self □Spouse □Parent □Guardian □Other	Effective Date	Expiration Date

ASSIGNMENT AND RELEASE: I hereby authorize payment directly to Ganesh Ramaswami, M.D. for all insurance benefits otherwise payable to me for service rendered. I understand that I am financially responsible for all charges, whether or not paid by insurances, and for all services rendered on my behalf or my dependents. I authorize any provider and/or supplier of services in this office to release any information required in securing the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand I will be subjected to a $30 service fee if my check is returned unpaid or if 24 hrs prior to my scheduled appointment. I fail to notify the office I will not be keeping my scheduled appointment.

Signature:_____Date:_____

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PATIENT MEDICAL INFORMATION

Date _____

Patient Name: _____Birthdate: _____ Age: _____

Chief complaint/reason for visit: _____

Date of first symptoms (required by insurance): _____

Symptoms: Describe _____

Family History: Varicose Veins? No Yes (please circle one)

Other Cardiac Conditions? _____

Medications – include dosage

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Allergies – include reaction

Latex allergy: No Yes

_____
_____
_____
_____
_____

Over the counter medications/supplements: _____

Bleeding/Clotting History

DVT/Blood clot _____When_____

Aspirin Daily	☐No		☐Yes		
Plavix	☐No		☐Yes		
Coumadin	☐No		☐Yes		
Do you smoke?	☐No	☐Yes	# Per Day	Years	Date Quit
Alcohol use	☐No	☐Yes	☐Occasionally	☐Daily	
Employed	☐No	☐Yes	Retired job	Years	

Previous surgeries: _____
_____

Other hospitalizations: _____
_____

TVS Staff ONLY – Reviewed By (initial): RN: _____ Physician: _____

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	NO	YES	Comment		NO	YES	Comment
Arthritis				Asthma			
Cancer				Hypertension			
Diabetes				Depression/Anxiety			
Stroke				COPD			
STDs				Bleeding Disorder			
Ulcers				Other			

Heart Disease: Atrial fibrillation CAD Stents _____

History of MI / Heart Attack: When: _____ Other: _____

Pregnant? No Yes Children: _____ Ages: _____

Height: _____ Weight: _____

Your Referring Physician:

_____ _____ _____

Doctors Name Address Phone

Your Primary Physician:

_____ _____ _____

Doctors Name Address Phone

Others Physicians Involved In Your Care:

_____ _____ _____

Doctors Name Address Phone

_____ _____ _____

Doctors Name Address Phone

Pharmacy Preference:

_____ _____ _____

Pharmacy Name Address Phone/Fax

Patient Signature:_____ **Date**:_____

TVS Staff ONLY – Reviewed By (initial): RN: _____ Physician: _____