NEW PATIENT REGISTRATION

Last Name: _____First Name: _____

Middle Initial: _____ Date of Birth: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip Code: _____

When trying to reach me, the BEST phone number is: _____

An alternative phone number is: _____Email: _____@_____

Can we send a text? Y N Leave a voicemail? Y N Send an email? Y N

Emergency Contact:

Name: _____Relation:_____Phone: _____

*********BRING A PHOTO ID AND YOUR INSURANCE CARD TO YOUR FIRST APPOINTMENT*********

PHYSICIAN INFORMATION

My primary care physician is: _____

The address is: _____

The phone number is: _____ The fax number is: _____

IMPORTANT NOTICE

Insurance requirements vary from plan to plan. You are responsible for obtaining any and all referrals required by your insurance. If you are not sure what your insurance requires to be seen by a specialist, contact them prior to your first appointment. Please make sure that referrals are in place prior to your visit.

If you have any questions, please do not hesitate to contact us at 978-922-8346

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NEW PATIENT MEDICAL HISTORY – PLEASE ANSWER ALL QUESTIONS BELOW

Name: _____ **Date of Birth:** _____

Please describe your principal symptoms by checking ALL that apply:

Aching and Pain	**Left** ____	**Right** ____	**How Long?** _____
Heaviness	**Left** ____	**Right** ____	**How Long?** _____
Itching	**Left** ____	**Right** ____	**How Long?** _____
Swelling	**Left** ____	**Right** ____	**How Long?** _____
Cramping	**Left** ____	**Right** ____	**How Long?** _____
Throbbing	**Left** ____	**Right** ____	**How Long?** _____
Restless Leg	**Left** ____	**Right** ____	**How Long?** _____
Skin Rash	**Left** ____	**Right** ____	**How Long?** _____
Discoloration	**Left** ____	**Right** ____	**How Long?** _____
Ulcers	**Left** ____	**Right** ____	**How Long?** _____
Tiredness/Fatigue	**Left** ____	**Right** ____	**How Long?** _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Does pain or cramping wake you up at night causing sleep disturbance?	**YES**	**NO**
Does over the counter pain medication help?	**YES**	**NO**
Does elevating your legs help?	**YES**	**NO**
Do you often miss work due to your symptoms?	**YES**	**NO**
Does walking or exercise cause pain?	**YES**	**NO**

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PRIOR TREATMENT and FAMILY HISTORY

Name: _____Date of Birth: _____

Have you ever worn compression stockings? YES NO

If yes, for how long? _____.

Did they help? YES NO

Have you ever been treated for varicose veins before? YES NO

If yes:

How long ago? _____ Where? _____

Who was the Doctor that treated you? _____

Does anyone in your family have a history of varicose veins, blood clots (DVTs), pulmonary embolisms, or other clotting disorders? Do you have any significant medical history that we should be aware of?

For example: surgeries and medical conditions requiring medication or treatment.

_____
_____
_____
_____
_____

Women: How many pregnancies did you have? _____

Did your symptoms worsen during pregnancy? YES NO

Have you had vulvar varicosities or unexplained pelvic pain? YES NO

What do you do for work? _____

Describe your exercise habits: _____

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Name: _____Date of Birth: _____

Do you travel frequently? YES NO

Do you have travel plans in the near future? YES NO (This may impact your treatment schedule).

If YES, tell us when, where, and mode of travel:

_____

MEDICATIONS

IMPORTANT: Do you take blood thinning medication? YES NO

If yes, which one(s) _____

Are you allergic to any medications, latex, or contrast dye? If yes, please provide details:

Medication	**Describe your reaction**

If you do not have a print-out of your current medications that you can bring to your first appointment, please list them below:

Name	**Dosage**	**Frequency**

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Name: _____**Date of Birth:** _____

How did you hear about us? _____

What are you hoping to achieve by having your varicose veins treated?

_____

_____

_____

_____

VASCULAR SPECIALISTS of the North Shore

PRIVACY NOTICE

Name: _____Date of Birth: _____

Introduction

The Vascular Specialists of the North Shore provides this notice to comply with the Privacy Regulation issued by the Department of Health and Human Services in accordance with the Health Insurance portability and Accountability Act of 1996 (HIPAA).

We understand that your health information is personal. Accordingly, we are committed to protecting the privacy of your individual health information. Therefore, this notice applies to all records of your care generated by our practice. This information is referred to as your medical record or Protected Health Information (PHI).

We are required by law to perform the following:

- Ensure that personal health information remains private.
- Distribute a notice of our legal duties and privacy practices.
- Follow the terms of the notice currently in effect.

How is PHI used and disclosed?

For purpose of treatment: we may disclose you PHI to physicians, nurses, students, and other healthcare personnel who provide you with healthcare services or are involved in your care. We may need to speak to other healthcare professionals who may be treating you or to whom we refer you.

For payment: we may disclose PHI in order to bill and collect payment from your insurance company or other third party, or to obtain authorization/approval, or determine if your plan will cover a treatment.

For healthcare operations: we strive to run our practice efficiently and to ensure that you receive the highest quality of care. This may include reviewing if new or existing treatments are effective, evaluating the performance of our staff and making decisions about your treatment. Your identity is removed when your personal health information is reviewed with our staff or for learning purposes.

As required by law: we will disclose PHI when required to do so by federal, state, or local law, or to avert a serious threat to health or safety.

For health oversight: we may disclose PHI to health oversight agencies for activities authorized by the law – these may include audits, investigations, inspections, and licensure.

VASCULAR SPECIALISTS of the North Shore

Name: _____**Date of Birth:** _____

What are your rights?

The following will summarize your rights regarding the health information we maintain about you. All requests must be made in writing to the Privacy Officer. A form will be provided at your request.

Right to inspect and copy your PHI: which may be used to make decisions about you. We may charge a fee for the cost of copying, mailing, or other supplies and services associated with this request. We have the right to deny this request under limited circumstances.

Right to an accounting of disclosures: with an exception for treatment, payment, and healthcare operations as previously described, we are able to fulfill your request covering a period of with our practice not to exceed a 6 year period. We will notify you of the cost involved and you may choose to withdraw or modify your request.

Right to request confidential communications: we will make a reasonable effort to communicate with you in the manner you request, i.e.: via phone, email or mail.

Right to a paper copy of this notice: a paper copy of this notice will be given to you during your visit or can be printed from our website www.vascularspecialistsnorthshore.com

Acknowledgement of receipt: we request that you sign the following sheet to acknowledge you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date it, then the acknowledgement will be part of your medical record.

Who will follow this notice?

The Vascular Specialists of the North Shore is composed of board certified physicians with specialized training and skill in the diagnosis and treatment of varicose veins, spider veins, venous disease of the legs, and vascular access management. Our patients benefit from effective, proven, minimally invasive and advanced medical procedures performed in a caring, comforting, patient centered environment. This notice applies to any healthcare provider authorized to enter information into your medical record, all areas of the practice, all Vascular Specialists staff, and our business associates.

Vascular Specialists Physician Team: Michael F. Mastromatteo, MD (medical director), James H. Balcom, MD, James C. Bass, MD, Veljko M. Popov, MD

We reserve the right to change or revise this notice as it relates to the information about you. We will post and offer you a current notice each time you enter our office.

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made available only with your permission. You may revoke permission at any time and this request must be in writing. Please understand that we are unable to take back any disclosures we have already made, and that we are required to retain our records of care provided to you.

ACKNOWLEGEMENT OF PRIVACY NOTICE

Patient name: _____Date of birth:_____

My signature below indicates that I have received a copy of the Privacy Policy from Vascular Specialists of the North Shore and its affiliates. I have read and understand its content. I was given the opportunity to have any questions answered.

Signature: _____Today's Date:_____