



APPOINTMENT DATE:

APPOINTMENT TIME:

**PATIENT INFORMATION**

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Email:			Social Security no.:		Birth date:	Age:	Sex: M / F
Street address:			Home phone no.: ( )		Cell phone no.: ( )		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ( )		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

**PLEASE LIST REFERRING & PRIMARY CARE PHYSICIAN**

Referring Physician:	Primary Care:
Phone:	Phone:

**IN CASE OF EMERGENCY**

Name of local friend or relative (not at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
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**INSURANCE INFORMATION**

Pretermination of benefits does not guarantee payment. Any remaining balance is the patient's responsibility. We advise you to know your insurance benefits and check with your insurance plan should you have questions regarding your benefits.

Primary Insurance:	Subscriber's name:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Secondary Insurance:	Subscriber's name:		Group no.:	Policy no.:	

**Office visits and procedures must be cancelled or rescheduled 48 hours prior to appointment time to avoid cancellation fees.**

Office visit cancellation fee: \$50.00

Procedure cancellation fee: \$100.00

Sclerotherapy cancellation fee: \$ 100.00

Unpaid balances transfer to a collection agency if a payment is not made within 60 days of billing date

By signing below, I acknowledge that I have read, understand, and agree to comply with the terms of your office/ financial policy and cancellation policy.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date

## Consent for Disclosure to Family Member and/ or Personal Representative

I have agreed to let certain individuals participate in the discussions and decisions related to my medical care. Therefore, I hereby give my permission for Athens Thoracic & Vascular Surgery, Dr. Maffei and his office staff to disclose my personal medical information to the following individual (s):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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Conditions for Disclosure (check the item(s) that apply)

\_\_\_\_\_ The Practice may disclose my personal health information to the individual(s) above **ONLY** in my presence.

\_\_\_\_\_ The Practice may disclose my personal health information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

\_\_\_\_\_ Other Conditions of Disclosure \_\_\_\_\_

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I understand that this consent is in effect until revoked by me by written notice to the practice.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed By \_\_\_\_\_ Title: \_\_\_\_\_

Print Name of Witness \_\_\_\_\_ Date: \_\_\_\_\_

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## NOTICE OF PRIVACY PRACTICES

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or a friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

To request restrictions, you must make your request in writing. In your request you need to indicate:

1. What information you want to limit.
2. Whether you want to limit use, disclosure or both.
3. To whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, or the like.

**Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

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### Effective Date

This notice is effective as of JANUARY 1 2017

Acknowledgment of Receipt

Notice of Privacy Practices

Your signature acknowledges that you have received a copy of the Notice of Privacy Practices.

Patient Name \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_



784 Prince Ave  
Athens, Georgia 30677  
TEL: 706-208-1144  
FAX: 706-208-9668  
[www.maffeiveincenter.com](http://www.maffeiveincenter.com)

### Authorization to Release Healthcare Information

Patient's name: \_\_\_\_\_  
Previous name: \_\_\_\_\_

Purpose of Release:    \_\_\_ Continuing Care    \_\_\_ Copies for own use    \_\_\_ Transition of Care  
                                 \_\_\_ Legal

I request and authorize \_\_\_\_\_  
to release healthcare information of the patient named above to:

**Maffei Vein Center**  
**Dr. Vincent Maffei**  
**784 Prince Ave**  
**Athens, Georgia 30606**

(Please list your primary care physician or Dr. who possesses pertinent medical records regarding your treatment with Dr. Maffei above)

This request and authorization applies to:  
\_\_\_ Healthcare information related to the following treatment, condition, or dates:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_ All healthcare information

\_\_\_ Other: \_\_\_\_\_

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of  
Responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT HISTORY**

**NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

Check current leg symptoms <u>OR</u> Symptoms experienced over the past 90 days	Right	Left
No symptoms		
Restlessness		
Aching		
Heaviness		
Itching		
Burning		
Cramping		
Throbbing		
Fatigue		
Swelling		
Other:		

Check if you have ever had:	Right	Left
Leg ulcers		
Bleeding from a vein		
Blood clots/Phlebitis		
Prior vein surgery		
Prior vein evaluation/Treatment		
Vein injections		
Leg injury /Trauma		

	Yes	NO
Do you have varicose or spider veins located in areas other than your legs? <b>Where?</b> _____		
Do your symptoms interfere with sleep?		
Do they interfere with walking?		
Does standing make symptoms worse? <b>How many hours do you stand daily?</b> _____		
Have you tried elevating legs to relieve discomfort? <b>How long?</b> _____		
Have you worn elastic support/ compression stockings? <b>How long?</b> _____		
Do you exercise? <b>How often?</b> _____		
Have you taken medication for leg symptoms? <b>How long?</b> _____ <b>What medication?</b> _____		

**DATE:** \_\_\_\_\_

On a scale of 1-10, with 1 being slightly bothersome and 10 being severely affecting your life, rate your vein disease: 1 2 3 4 5 6 7 8 9 10

**Please list any other previous surgeries and dates:**  
(Excluding vein surgeries)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications:** (Include prescription, OTC, supplements)

Medication	Dosage	How Often

List additional medications on back / OR attach a list

**Medication Allergies:** Latex/Rubber \_\_\_\_ Betadine\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**No known medication allergies** \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes, how much do you smoke and how long have you smoked? \_\_\_\_\_

Please list your work occupation:

\_\_\_\_\_

**For Women Only:**

Are you pregnant or considering pregnancy in the near future? \_\_\_\_\_

Are you breastfeeding? \_\_\_\_\_

Do symptoms get worse during pregnancy?

Number of pregnancies: \_\_\_\_\_ Deliveries: \_\_\_\_\_

Do you use birth control pills or take estrogen replacement therapy? \_\_\_\_\_

# PATIENT'S PERSONAL HISTORY

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

***DO YOU HAVE OR HAVE YOU HAD: (Please circle yes or no. If yes, provide date of occurrence).***

No Yes \_\_\_ Cancer

## HEAD AND NECK

No Yes \_\_\_ Tonsillitis

## NEURO

No Yes \_\_\_ Seizures

No Yes \_\_\_ Stroke

No Yes \_\_\_ Epilepsy

No Yes \_\_\_ Migraine

No Yes \_\_\_ Tremors

## PULMONARY

No Yes \_\_\_ Tuberculosis

No Yes \_\_\_ Bronchitis

No Yes \_\_\_ Pneumonia

No Yes \_\_\_ Hay Fever

No Yes \_\_\_ Exposure to Asbestos

No Yes \_\_\_ Blood Clot in Lung

## CV

No Yes \_\_\_ Heart Attack

No Yes \_\_\_ Heart Failure

No Yes \_\_\_ Rheumatic Heart Disease

No Yes \_\_\_ Congenital Heart Problem

No Yes \_\_\_ High Blood Pressure

## ENDOCRINE

No Yes \_\_\_ Thyroid Disease

No Yes \_\_\_ Diabetes

## GI/GU

No Yes \_\_\_ Hepatitis

No Yes \_\_\_ Gall Bladder Disease

No Yes \_\_\_ Stomach Ulcers

No Yes \_\_\_ Pancreatic Disease

No Yes \_\_\_ Kidney Disease

No Yes \_\_\_ Bladder Infection

## MUSCULOSKELETAL

No Yes \_\_\_ Arthritis

No Yes \_\_\_ Poor Circulation

No Yes \_\_\_ Gout

## DERM

No Yes \_\_\_ Psoriasis

No Yes \_\_\_ Dermatitis

No Yes \_\_\_ Eczema

## COAGULOPATHY

No Yes \_\_\_ Bleeding Tendency

No Yes \_\_\_ High Fever After  
Blood Transfusion

No Yes \_\_\_ Blood Clots

## PSYCH

No Yes \_\_\_ Nervous Breakdown

***DO YOU KNOW OF ANY BLOOD RELATIVE WHO HAS OR HAS HAD (Circle yes or no. If yes, give relationship)***

No Yes \_\_\_\_\_ Tuberculosis

No Yes \_\_\_\_\_ Seizures

No Yes \_\_\_\_\_ Stroke

No Yes \_\_\_\_\_ Cancer

No Yes \_\_\_\_\_ Epilepsy

No Yes \_\_\_\_\_ Diabetes

No Yes \_\_\_\_\_ Hepatitis

No Yes \_\_\_\_\_ Arthritis

No Yes \_\_\_\_\_ Migraine

No Yes \_\_\_\_\_ Hay Fever

No Yes \_\_\_\_\_ Gall Bladder Disease

No Yes \_\_\_\_\_ Thyroid Disease

No Yes \_\_\_\_\_ Asthma

No Yes \_\_\_\_\_ Heart Attack

No Yes \_\_\_\_\_ Heart Failure

No Yes \_\_\_\_\_ Stomach Ulcers

No Yes \_\_\_\_\_ Kidney Disease

No Yes \_\_\_\_\_ Rheumatic Heart Disease

No Yes \_\_\_\_\_ Congenital Heart  
Problem

No Yes \_\_\_\_\_ Bleeding Tendency

No Yes \_\_\_\_\_ High Blood Pressure

No Yes \_\_\_\_\_ Blood Clots

No Yes \_\_\_\_\_ Poor Circulation

No Yes \_\_\_\_\_ Nervous Breakdown

No Yes \_\_\_\_\_ Suicide

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date