CORONADO
VEIN CENTER

Patient Registration
(PLEASE PRINT)

First Name: _____ Middle Initial: _____

Last Name: _____ Sex: M F Insurance:_____

Social Security #: _____ Date of Birth: _____/_____/_____

Mailing Address: _____

Primary Care Physician:_____

Email Address: _____

Phone Number: Home: _____ Mobile: _____

Work: _____

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

Employment Status: ☐ Retired ☐ Employed ☐ Student

Race: _____ Ethnicity: _____ ☐ Decline to Report

Preferred Language: _____

Emergency Contact

First & Last Name: _____ Relationship:_____

Primary Phone: _____ Secondary Phone: _____

Address: _____

_____

Authorization for the Release of Medical Information
Coronado Vein Center

Authorization for use/or disclosure of protected health information. *Patients: Please fill bottom portion only.*

I, hereby authorize_____
(Name of Disclosing Party)

_____
Address

_____ _____ _____
City State Zip

_____ _____
Phone Fax

To Disclose to the **Coronado Vein Center**

_____
Address

_____ California _____
City Zip

_____ _____
Phone Fax

Name of Patient_____DOB_____

Specify the records to be disclosed:

*Medical Information_____Date_____
*X-Ray Results_____Date_____
*Lab Results_____Date_____
*Progress Notes_____Date_____
*Consultation Report_____Date_____
*Other_____Date_____

----------*Above For Office Use Only*----------

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here_____.

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Signed_____ Witness Signed_____

Name_____ Name_____

Date_____ Relationship to Patient_____

PERSONAL REPRESENTATIVE AUTHORIZATION
FOR MEDICAL RELEASE FORM

I, authorize The Coronado Vein Center and staff to speak to the following family members or my personal representative regarding:

▫ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurses and doctors notes and any other non-medical information in my file.

▫Only the following types of information:

_____

_____

_____

The above medical information shall only be released to the following persons:

Family Member/Personal Representatives Relationship

_____

_____

_____

I understand that I may terminate this Medical Authorization Form. I must notify The Coronado Vein Center in writing regarding termination and effective date.

This authorization shall remain valid until revoked in writing.

I know that I am entitled to receive a copy of this agreement.

Signature: _____ Date: _____

Print Name: _____

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

_____

PATIENT NAME

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that the Coronado Vein Center may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

The Coronado Vein Center has a detailed document called the "***Notice of Privacy Practices***". It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the "Notice" before signing this agreement. If I ask, the Coronado Vein Center will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow the Coronado Vein Center to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except that the extent that the Coronado Vein Center has taken action relying on this consent.

_____ _____

SIGNATURE (Patient or Legal Authorized Representative) **DATE**

_____ _____

RELATIONSHIP TO PATIENT if signed by another party **DATE**

You may obtain a copy of our *Notice of Privacy Practices,* including and revisions of our "*Notice"* at any time by contacting Coronado Vein Center, Redding at 530-244-3278.

CORONADO
VEIN CENTER

Photo Release Consent

At the Coronado Vein Center, photographs and in rare cases, videos are taken at various visits for the reasons of medical documentation and for use as a medical record. These photos are sometimes required by insurance companies to justify authorization for certain procedures. Photos can also be used for educational purposes as well as advertisement purposes. The below release pertains to use of photos in educational, advertisement, or other non-medical documentation purposes.

I consent for medical photographs/videos to be taken of me by Dr. Robert Coronado/Coronado Vein Center or its representatives. I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals. By consenting to these medical photographs, I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. Refusal to consent to *the release* of photographs or videos for publication will in no way affect the medical care I receive. If I wish to withdraw my consent in the future, I may do so with a written request.

I authorize the use of these images/videos: (Please initial indicating YES or NO below)

_____YES _____NO For demonstration purposes, including but not limited to an office photo album or other printed marketing material

_____YES _____NO For digital advertisement purposes, including but not limited to our website, Facebook and Instagram

_____YES _____NO For educational purposes, including but not limited to professional journals and presentations

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand, and that by refusing to release my photos or videos, I am not exempting myself from having photos taken for medical documentation purposes.

_____ _____

Patient Signature Witness

_____ _____

Patient Printed Name Date

CORONADO
VEIN CENTER

Varicose Veins Questionnaire

Patient Name: _____ Sex: _____

Date of Birth: _____ Primary Care Doctor: _____

Why are you here today? _____ Insurance Name: _____

How did you hear about us? _____

Have you ever or do you currently have a work-related injury having to do with your condition? Yes / No

Do you have a cardiologist? Yes / No Doctor: _____

Do you experience any of the following symptoms in your legs?

(please specify right, left or both legs)

_____ varicose veins
_____ ulcers/non-healing wounds
_____ aching/pain
_____ heaviness
_____ tiredness/fatigue
_____ itching
_____ discoloration
_____ burning
_____ swollen ankles
_____ leg cramps
_____ restless legs
_____ throbbing

Have you ever seen a physician for varicose veins? Yes / No

Doctor: _____ Date _____

Do you wear compression stockings? Yes / No

If yes, for how long? _____

Have you ever had vein surgery, stripping or injections? Yes / No

If yes, when and which leg? _____

Have you ever had blood clot? Yes / No

If yes, when and which leg? _____

Have you ever had phlebitis? Yes / No

If yes, when and which leg? _____

Have your symptoms gotten worse in the past few months? Yes / No

Do you elevate your legs to relieve discomfort? Yes / No

Cardiovascular History

Please check any item that applies to you. Please provide date and where it occurred:

_____ Heart Attack
_____ Heart Surgery (Bypass or Valvular)
_____ Congestive Heart Failure
_____ Ultrasound of your legs
_____ Peripheral Artery Bypass
_____ Cardiac Angiogram or Cath
_____ Cardiac Angioplasty / Stent
_____ Peripheral Angiogram
_____ Peripheral Artery Stent

Have you ever had problems with anesthesia? If yes, please explain:

Allergies (please list medication and reaction)

Medication History

Please list all medications, Prescriptions, Aspirin products, Over the Counter, Vitamins and Nutritional Supplements

Name of Drug	Dose (mg)	How often you take medication

Are you taking Coumadin (warfarin)? If so, which doctor follows your Coumadin Therapy:

Yes / No _____

Are you or have you been treated for any medical problems?

____ Hypertension
____ Hypercholesterolemia
____ Renal Disease
____ Diabetes
____ Cancer
____ Stroke
____ TIA
____ Mental Health Illness
____ Depression
____ Anxiety Disorder
____ # of Term Pregnancies
____ Deep Vein Thrombosis
____ Pulmonary Embolism
____ Atrial Fibrillation
____ Cellulitis
____ Lymphedema

Surgical History

List any surgeries that you have had:

Social History & Habits

This will remain strictly confidential, please be honest in your responses. We realize these may be sensitive issues, but they are very important to know in treating your cardiovascular health

_____ Tobacco: Currently smoking? Yes / No Previous smoker Never Smoked

When did you last use tobacco? _____ packs per day _____ for how long _____

How soon after waking up do you use tobacco? _____

Are you interested in quitting? Yes / No

_____ Alcohol: How much and how often? _____

_____ Caffiene: Type(s) _____ How much per day ? _____

_____ Recreational Drugs (Current/past) What substance and last use? _____

Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

Father Yes / No Mother Yes / No

Brother(s) Yes / No Sister(s) Yes / No

Occupation: _____ Employer: _____

Do you exercise? Yes / No If yes, what type? _____

How many days per week? _____ How many minutes per day? _____

Do your symptoms get worse with exercise? Yes / No

Have you had the flu shot since the most recent September 1st? Yes / No

Symptom Review

Check any of the following symptoms you have experienced in the past month:

_____ Fatigue
_____ Fever
_____ Headaches
_____ Loss of appetite
_____ Weakness
_____ Weight gain
_____ Weight loss
_____ Cold
_____ Cough (productive / dry)
_____ Nose bleeds
_____ Hearing loss
_____ Ringing in the ears
_____ Sore throat
_____ Acid reflux
_____ Abdominal Pain
_____ Blood in stool
_____ Constipation
_____ Diarrhea
_____ Difficulty swallowing
_____ Heartburn
_____ Nausea
_____ Vomiting
_____ Bleeding
_____ Easy bruising

_____ Carpal Tunnel
_____ Fracture (bone)
_____ Joint pain
_____ Joint stiffness
_____ Joint swelling
_____ Leg cramps
_____ Muscle aches
_____ Dizziness
_____ Gait abnormality
_____ Insomnia
_____ Memory loss
_____ Seizures
_____ Tingling/numbness
_____ Blurry vision
_____ Diminished vision
_____ Eye irritation
_____ Loss of vision
_____ Seasonal eye symptoms
_____ Blood in urine
_____ Difficulty urinating
_____ Frequent urination
_____ Urination at night, _____How often?
_____ Urinary incontinence
_____ Voiding dysfunction