Name:______________________________

Date:______________________________

DOB:______________________________ SS #__________________

Address:______________________________ How did you hear about us?______________

City:______________________________ Maital Status: S M D W

State:__________ Zip Code:__________ Sex: M F Age:______________

Phone # Priority______________________ Okay to leave message: Yes or No

Phone# Secondary ____________________ Okay to leave message: Yes or No

Emergency Contact:____________________ Relation to Patient:__________________

Phone#______________________________ Okay to leave message: Yes or No

E-Mail: ______________________________ Access your Electronic Records: Yes or No

Primary Care Physician:________________ Phone:____________________________

Referring Physician:___________________ Phone:____________________________

Pharmacy:__________________________ Phone:____________________________

Primary Insurance:____

Secondary Insurance:____

Occupation:____

Employer:__________________________ Business Phone: ____________________

Dr. White's Vein Center, PLLC
1311 Pineview Drive Suite 200
Morgantown, WV 26505

Dr. White's Vein Center

Health History and Questionnaire

Date: ________________

Chief complaint: ____________________ Length of time? ________

Compression stockings/socks? ________ Length of time? ________

Allergies: (medications, environmental)

Medical & Surgical History

Pharmacy/ Medications

Father	**Mother**	**Brother**	**Sister**
Hypertension	Hypertension	Hypertension	Hypertension
Heart Disease	Heart Disease	Heart Disease	Heart Disease
Cancer	Cancer	Cancer	Cancer
Diabetes	Diabetes	Diabetes	Diabetes
Varicose Veins	Varicose Veins	Varicose Veins	Varicose Veins
Stroke	Stroke	Stroke	Stroke
Lung Disease	Lung Disease	Lung Disease	Lung Disease
Migraine	Migraines	Migraines	Migraines
Kidney Disease	Kidney Disease	Kidney Disease	Kidney Disease

Social History:

Smoke ________ Alcohol ________ Drink Caffeine _______ Wear seatbelt ______

Having a living will ________ Medical Power of Attorney _______ Exercise _________

Preventative Health:

Mammogram year _______ Colonoscopy year______

Influenza Vac. year _______ Pneumonia Vac. year _______

Dr. White's Vein Center

Venous Health History Form

Name ______________________________ DOB ____________

PCP Name _________________________

Referring Physician ___________________ How did you hear about us? __________

Vascular History	**Yes**	**No**	**Vein Treatment History**	**Yes**	**No**
Do you have or have you ever been diagnosed with:			Have you ever been treated for varicose veins with:		
Varicose Veins			Sclerotherapy		
Phlebitis (vein redness/tenderness)			Laser Therapy (spider veins)		
Blood clot			Phlebectomy		
Deep Vein Thrombosis (DVT)			Vein stripping surgery		
Diabetes (Type 1 or Type 2)			RF ablation		
Saphenous vein reflux			VeaSeal Closure System		
Do you experience any of the following in your legs?	**Yes**	**No**	**Personal History**	**Yes**	**No**
Aching/ Pain			Pregnancies? How many? ____		
Heaviness			Does your work require:		
Tiredness/Fatigue			Prolonged sitting		
Itching/Burning			Prolong standing		
Swelling			Heavy lifting? How many lbs ___		
Throbbing					
Restless legs					
Skin Ulcers					

Patient Name________________________________

Date:______/______/______

Face photos taken:_______
Leg photos taken:________

Weight:__________

Height:__________

RR:____________

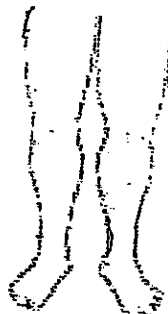
HR:____________

BP:______/______

SpO2:__________%

L **R**

Thigh______ **Thigh** _______



Calf_______ **Calf**________

Ankle_____ **Ankle**________

Floor To Knee______

Floor to Thigh______

Dr. White's Vein Center
BCBS Advance Beneficiary Notice (ABN)

A. Patient Name: ______________________________

B. Identification Number: ______________________________

1. Advance Beneficiary Notice of Noncoverage (ABN)
2. NOTE: If BCBS doesn't pay for C. below, you may have to pay.

BCBS does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect BCBS may not pay for the D. below.

C.	D. Reason BCBS May Not Pay:	E. Estimated Cost
Ultrasound	Some plans are not paying	$125 -200

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the C. listed above.

F. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the C. listed above. You may ask to be paid now, but I also want BCBS billed for an official decision on payment, which is sent to me on an EOB. I understand that if BCBS doesn't pay, I am responsible for payment.

☐ **OPTION 2.** I want the C. listed above, but do not bill BCBS. You may ask to be paid now as I am responsible for payment.

☐ **OPTION 3.** I don't want the C. listed above. I understand with this choice I am not responsible for payment.

Signing below means that you have received and understand this notice.

G. Signature:	H. Date: