PINNACLE
VEIN & VASCULAR CENTER
THE PEAK OF GOOD HEALTH

Dear New Patient:

Welcome to Pinnacle Vein and Vascular Center. We are pleased you have chosen us for your healthcare needs and are confident that you have made the right decision. We want your visit with us to be a success. We have included a checklist to help you prepare for our time together. It is very important that you complete the attached forms, and bring them with you to your appointment. This will reduce your registration time on the day of your visit and provide your vascular provider with important information needed to provide you with highest quality of care:

_Filled registration forms
_ Insurance card
_ Photo ID
_ Any pertinent medical documentation (Labs, Diagnostic tests)

Your appointment is scheduled for _____ at _____, at the following location listed below:

Sun City 9744 W Bell Rd. Suite A Sun City, AZ 85351 North East Corner of 98th Ave & Bell	**Gilbert** 3615 S Rome St. Gilbert, AZ 85297 Off the San Tan 202 and Val Vista Inside Desert Spine
Phoenix Estrella Medical Plaza II 9321 W Thomas Rd. Suite 300 Phoenix, AZ 85037 Off the 101 and Thomas	**Avondale** McDowell Medical Plaza 10825 W McDowell Rd. Suite 100 Avondale, AZ 85392 Off 107th Ave and McDowell

We ask that you arrive 20 minutes before your scheduled new patient appointment. We have to check your insurance card every visit and please have this and your copay ready. We will also ask to see your photo ID. We cannot see you as a new patient unless you bring your photo ID with you to your initial visit.

Office hours are Monday through Friday 7:30am to 4:00pm.
Prescription refills will only be refilled during office hours.

If you have any questions please feel free to call our office at 888.553.VEIN (8346). We look forward to meeting you in person.

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New Patient Paperwork

Pinnacle Vein and Vascular Center
Phone: 1.888.553.VEIN (8346) | Fax: 623.404.4530
www.pinnaclevein.com

Patient Information:

Name: _____ Date of Birth: _____

Sex: _____ Race: _____ Marital Status: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Work #: _____

Cell Phone: _____ Home Phone: _____

Best Contact (Circle One): Home/Work/Cell/E-mail | Email: _____

Emergency Contact Name: _____ Phone: _____

Referring Doctor: _____ Primary Physician: _____

Preferred Pharmacy: _____ Phone: _____

How Did You Hear About Us? (Circle One): Internet Hospital Previous-Patient Referral

TV Walk-in Facebook Insurance Co Billboard Other: _____

Insurance Information:

Primary Insurance: _____ Policy Number: _____

Group Number: _____ Policy Holder: _____

Policy Holder SS #: _____ Policy Holder DOB: _____

Secondary Insurance: _____ Policy Number: _____

Group Number: _____ Policy Holder: _____

Policy Holder SS #: _____ Policy Holder DOB: _____

Patient Signature: _____Date: _____

Past Surgical History: Please list any surgeries you have had, including previous vein treatment.

Drug Allergies: Please list any allergies to any medication

Medication	**Dose**	**Frequency**

Family History: Please list any relevant family history of medical illness or disease

Mother	
Father	
Sibling	

Patient Past Medical History: Please mark all that apply

___ Abdominal Aortic Aneurysm ___Cancer ___ High Blood Pressure

___ Heart Disease ___Pacemaker ___ High Cholesterol

___ Congestive Heart Failure ___ Atrial Fibrillation ___ Lupus

___ COPD ___ History of DVT ___ Hepatitis B

___ Kidney Disease ___ History of PE ___ Hepatitis C

___ Renal Failure/ Dialysis ___ Depression ___ Thyroid Disease

___Bleeding or Clotting Disorder ___ Diabetes ___ Migraines

___ HIV or AIDS ___ Heart Attack ___ Other

___Arthritis ___ Stroke _____

Patient Current Symptoms: Please mark all that apply

___Blurred/Loss of Vision ___ Fatigue ___Abdominal Pain

___Dizziness/Vertigo ___Palpations ___Chest Pain

___Headaches ___Weight Gain ___Shortness of Breath

___Seizures ___Weight Loss ___ Other

___Anxiety ___ Allergies _____

___Depression ____Joint Pain _____

Are you currently on blood thinners? ____Yes _____No

If yes, for how long? _____

Social History:

Do you now or have you ever used tobacco? ___Yes ____No

Packs per day_____ Date quit, if applicable_____

Average number of alcoholic beverages per week: ___None ____ 1-5 ___ 6-10 ___ 10+

Do you feel safe driving? ___Yes ____No

Do you feel you are a harm to yourself or others? ___Yes ____No

Do you feel safe at home? ___Yes ____No

Females Only:

Are you pregnant or plan on becoming pregnant? ___Yes ___No

Are you currently breastfeeding? ___Yes ___No

Lower Extremity Vascular History

Only fill out this portion if you are being seen today for symptoms in your legs or Varicose Veins.

Do you have any of the following symptoms?

___Red/purple spider veins ___Bulging veins ___Calf/thigh/buttock pain

___Skin discoloration ___Venous ulcers/open wounds ___Black toe/Gangrene

___Leg pain ___Cramping ___Itching

___Swelling ___Burning ___Heaviness

___Bleeding from veins ___Restless legs

Years with varicose veins? _____ Years with venous ulcers? _____

Please mark any factors that agitate your leg discomfort:

___Prolonged standing ___Tender to touch ___Walking, if yes

___Prolonged sitting ___Pregnancy distance walking before pain

___Exercise ___Around/during menstrual cycle _____

Please mark any methods you have used to relive pain:

___Compression hose/wraps ____Cold Compress ___Pain medication

___Exercise ___Heat ___Other

___Leg elevation ___Massage _____

Have you had previous vein treatment?

By whom? _____ When? _____

- If so, which of the following methods was used:

___Cosmetic Injections ___Laser catheter ablation ___Other

___Radiofrequency closure ___Vein stripping ___Unknown

I hereby state that the information I listed above is accurate and complete. I acknowledge that I am responsible for notifying Pinnacle Vein and Vascular Center of any changes made to my contact information and/or insurance information. Date: ___/___/____

Signature of Patient or Responsible Party: _____

Printed name of Patient or Responsible Party: _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

By signing this form, I understand that:

· Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

· The practice reserves the right to change the privacy policy as allowed by law.

· The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointments? ___ Yes ___No

May we leave a message on your answering machine at home or cell phone? ___ Yes ___No

May we discuss your medical condition with any member of your family? ___ Yes ___No

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____

Date:_____

Phone: 1.888.553.VEIN(8346) | Fax: 623.404.4530

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