**Sonoma Vein Cardiovascular Laser Group**

**990 Sonoma Ave, Suite 2**

**Santa Rosa, CA 95404**

**(Phone) 707-636-8346 \* (Fax) 707-205-1008**

|  |
| --- |
| **Patient Information** |
| Name (**Last, First, Middle**): Date of Birth: Social Security #: Gender: |
| / / |
| Preferred Pronoun(s): Nickname: Marital Status: |
|  |
| Address : City, State, Zip: |
|  |
| Mailing Address (if different): |
|  |
| Best number to contact you: Alternate Number: Driver’s License # or ID: (must present) |
|  |
| Email: |
| Who referred you to our office: Primary Physician: |
| **Emergency contact(s)** |
| Name: Phone Number: Relationship: |
|  |
| Name : Phone Number: Relationship: |
|  |
| Name of Insurance and ID # **MUST PRESENT AT ALL VISITS** **\*\*\*ALL COPAYMENTS DUE AT TIME OF VISIT\*\*\*** |
|  |
| Spoken Language: \_\_\_English \_\_\_Spanish Other: |
| Race:  \_\_\_American Indian/Alaska Native \_\_\_Asian \_\_\_Black/African American \_\_\_Caucasian \_\_\_Hispanic/Latino  \_\_\_Native Hawaiian/Other Pacific Islander \_\_\_Other \_\_\_More than one \_\_\_Not reported |
| I hereby authorize Sonoma Vein/Santa Rosa Cardiology Medical Group, Inc. to furnish information to insurance carriers concerning my illness and treatment, and I hereby assign insurance benefits/payments to be paid directly to Santa Rosa Cardiology Medical Group, Inc. for medical services rendered to me. **I understand I am responsible for any amount(s) not covered by insurance.**  Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  10/24/2024 updated tfh |

**SONOMA VEIN CARDIOVASCULAR LASER GROUP**

**CANCELLATION AND NO-SHOW POLICY**

**General appointment:** If you cancel your appointment less than 24 hours prior to your appointment time or if you fail to show up for your appointment altogether, you will be charged a **$75.00** fee.

**Ultrasound appointment:** If you cancel your appointment less than 24 hours prior to your appointment time or if you fail to show up for your appointment altogether, you will be charged a **$100.00** fee.

**Surgery appointment:** If you cancel your appointment less than 48 hours prior to your appointment time or if you fail to show up for your appointment altogether, you will be charged a **$200.00** fee.

**REMEMBER: APPOINTMENTS ARE ULTIMATELY THE PATIENT’S RESPONSIBILITY**

I understand and agree to the terms and conditions stated above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature (Patient or Parent Guardian) Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Name/Relationship**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness Signature (Office use only) Date**

**SONOMA VEIN**

**CARDIOVASCULAR LASER GROUP**

990 Sonoma Avenue Suite 2, Santa Rosa, CA 95404

Phone: 707-636-8346 Fax: 707-205-1008

**CONSENT For Purposes of Treatment, Payment**

**And Healthcare Operations**

I consent to the use or disclosure of my protected health information by **Sonoma Vein Cardiovascular Laser Group** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Sonoma Vein Cardiovascular Laser Group.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Sonoma Vein Cardiovascular Laser Group** has taken action in reliance on the consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or Personal Representative) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name of Patient (or Personal Representative)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority

Our office will provide you, the patient, or patient’s representative, a copy of our HIPAA Notice of Privacy Practices upon request. Please advise the front desk or any staff member if you would like a copy.

Thank you.

Please sign below if you wish to decline a copy of the notice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient / Representative Date

**SONOMA VEIN**

**CARDIOVASCULAR LASER GROUP**

990 Sonoma Avenue Suite 2, Santa Rosa, CA 95404

Phone: 707-636-8346 Fax: 707-205-1008

**VENOUS HISTORY**

**What are you being seen for?**

\_\_\_ Varicose Veins \_\_\_ Venous Ulcers \_\_\_ Edema/ Swelling

\_\_\_ Spider Veins \_\_\_ Leg Pain Other \_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY – provide estimates for date of occurrence.**

1. Have you ever had vein stripping or ablation? \_\_\_ Yes \_\_\_ No When \_\_\_\_\_\_\_\_
2. Have you ever had vein injections? \_\_\_ Yes \_\_\_ No When \_\_\_\_\_\_\_\_
3. Have you ever had phlebitis? \_\_\_ Yes \_\_\_ No When \_\_\_\_\_\_\_\_
4. Have you ever had bleeding varicose veins? \_\_\_ Yes \_\_\_ No When \_\_\_\_\_\_\_\_
5. Have you ever had venous sores or ulcers? \_\_\_ Yes \_\_\_ No When \_\_\_\_\_\_\_\_
6. Have you ever had a blood clot or DVT? \_\_\_ Yes \_\_\_ No When \_\_\_\_\_\_\_\_
7. Have you ever had a pulmonary embolism? \_\_\_ Yes \_\_\_ No When \_\_\_\_\_\_\_\_
8. Have you ever had migraines? \_\_\_ Yes \_\_\_ No When \_\_\_\_\_\_\_\_
9. Have you been diagnosed with a PFO or ASD? \_\_\_ Yes \_\_\_ No When \_\_\_\_\_\_\_\_
10. Do you usually take Valium before minor procedures? \_\_\_Yes \_\_\_\_No
11. Have you ever fainted or felt nauseous while giving blood? \_\_\_Yes \_\_\_\_No
12. Are you currently pregnant or breast feeding? \_\_\_ Yes \_\_\_ No

**FAMILY HISTORY**

Does anyone in your family have a history of varicose veins, blood clots, pulmonary embolism or ulcers?

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

**SYMPTOMS**

Do you experience any of the following symptoms that interfere in activities of daily living?

\_\_\_ Aching/pain \_\_\_ Heaviness \_\_\_ Tiredness/fatigue

\_\_\_ Itching/burning \_\_\_ Swelling/edema \_\_\_ Restless legs

What pain medication have you taken for relief of symptoms?

\_\_\_ Aspirin \_\_\_ Ibuprofen \_\_\_ Aleve \_\_\_ Tylenol Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSERVATIVE THERAPIES**

Have you tried the following to improve your symptoms? Provide estimates for length of time.

1. Exercise 2-3 times a week? \_\_\_ Yes \_\_\_ No How long? \_\_\_ wks/mths/yrs
2. Weight loss or diet changes? \_\_\_ Yes \_\_\_ No How long? \_\_\_ wks/mths/yrs
3. Avoidance of prolonged standing? \_\_\_ Yes \_\_\_ No How long? \_\_\_ wks/mths/yrs
4. Elevation of your legs? \_\_\_ Yes \_\_\_ No How long? \_\_\_ wks/mths/yrs
5. Compression stockings? \_\_\_ Yes \_\_\_ No How long? \_\_\_ wks/mths/yrs

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name/Relationship Date of Birth Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Patient or Parent Guardian)

**Sonoma Vein Cardiovascular Laser Group**

**Patient Questionnaire**

**DATE**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NAME** | | | | | | | | | | **PAST MEDICAL HISTORY** | | | **NO** | | **YES (or History)** | | **CURRENT PROBLEM** |
| DOB HEIGHT WEIGHT | | | | | | | | | | HIATAL HERNIA | | |  | |  |  | |
| HEARTBURN | | |  | |  |  | |
|  | | | | | | | | | | GALLBLADDER DISEASE | | |  | |  |  | |
| **RISK FACTORS** | **Year Diagnosed** | | | | **NO** | **YES/ or History** | | **CURRENT PROBLEM** | | LUNG DISEASE | | |  | |  |  | |
| BLOOD CLOT IN LUNGS | | |  | |  |  | |
| DIABETES |  | | | |  |  | |  | | SLEEP APNEA | | |  | |  |  | |
| HYPERTENSION |  | | | |  |  | |  | | TB (Tuberculosis) | | |  | |  |  | |
| HIGH CHOLESTEROL |  | | | |  |  | |  | | HEPATITIS | | |  | |  |  | |
| VASCULAR DISEASE |  | | | |  |  | |  | | DRUG RESISTANT INFECTIONS | | |  | |  |  | |
|  | | | | | | | | | | ARTHRITIS | | |  | |  |  | |
| **FAMILY HISTORY** | | | | | | | **YES** | | **NO** | GOUT | | |  | |  |  | |
| HEART DISEASE (ANY AGE) | | | | | | |  | |  | SCIATICA | | |  | |  |  | |
| HEART DISEASE (UNDER 60yo) | | | | | | |  | |  | DIFFICULTY WALKING | | |  | |  |  | |
|  | | | | | | | | | | MACULAR DEGENERATION | | |  | |  |  | |
| **SOCIAL HISTORY** | | | | | | | | | | EYE INJURY | | |  | |  |  | |
| **MARITAL STATUS (circle)** | | | | | | | | | | ABDOMINAL AORTIC ANEURYSM | | |  | |  |  | |
| SINGLE | | DIVORCED | | | | | | | | LOSS OF CONSCIOUSNESS | | |  | |  |  | |
| MARRIED | | WIDOWED | | | | | | | | KIDNEY STONES | | |  | |  |  | |
| SEPARATED | | DOMESTIC PARTNER | | | | | | | | KIDNEY DISEASE | | |  | |  |  | |
| **OCCUPATION/FORMER** | | | | | | | | | | MISCARRIAGES | | |  | |  |  | |
| **Title:** | | | | | | | | | | CANCER/TYPE: | | | | | | | |
| **CIRCLE IF APPLIES:** DISABLED RETIRED | | | | | | | | | | OTHER: | | | | | | | |
| **NUMBER OF CHILDREN** | | | | | | | | | |
| MALE/S: FEMALE/S: | | | | | | | | | |
|  | | | | | | | | | | **LIST PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS INJURY** | | | | | | | |
| **HABITS** | | | | | | | | | | DATE | PROCEDURE TYPE | | | REASON | | | |
| **DIETARY (circle)** | | | | | | | | | |  |  | | |  | | | |
| REGULAR | | | DIABETIC | | | | | | |
|  |  | | |  | | | |
| LOW FAT/CHOL | | | RENAL | | | | | | |
| LOW SALT | | | LOW CARB | | | | | | |  |  | | |  | | | |
| NO SALT ADDED | | | WEIGHT LOSS | | | | | | |
| VEGETARIAN | | | VEGAN | | | | | | |  |  | | |  | | | |
| **TOBACCO (circle)** | | | **ALCOHOL (circle)** | | | | | | |
| NON SMOKER | | | NEVER DRINKS | | | | | | |  |  | | |  | | | |
| PRESENT SMOKER | | | PRESENTLY DRINKS | | | | | | |
| FORMER SMOKER | | | QUIT DRINKING | | | | | | |  |  | | |  | | | |
| YEAR QUIT SMOKING: | | | YEAR QUIT DRINKING: | | | | | | |
| HOW MANY YRS HAVE/DID YOU SMOKE FOR? | | | AVERAGE NUMBER OF DRINKS? | | | | | | | **MEDICATION ALLERGIES OR INTOLERANCE** | | | | | | | |
| MEDICATION | | REACTION | | | | | |
| AVERAGE PPD? | | | PER: DAY, WEEK, MONTH, YEAR | | | | | | |  | |  | | | | | |
| **EXERCISE (circle)** | | | | | | | | | |
| SEDENTARY | | | | ACTIVE LIFESTYLE | | | | | |  | |  | | | | | |
| REGULAR | | | | OCCASIONAL | | | | | |
| PHYSICALLY UNABLE TO EXERCISE | | | |  | | | | | |  | |  | | | | | |
| TYPE OF EXERCISE: Weightlifting Aerobics | | | | | | | | | |
| DO YOU HAVE AN ADVANCE DIRECTIVE (DURABLE POWER OF ATTORNEY FOR HEALTH CARE)? **YES NO** | | | | | | | | | |  | |  | | | | | |
| IF YES, INCLUDE NAME/RELATIONSHIP TO PATIENT: | | | | | | | | | |  | | | | | | | |

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **REVIEW OF SYSTEMS** | **NO** | **YES/or History** | **CURRENT PROBLEM** | **MEDICATION LIST** | | | |
| CATARACTS |  |  |  | **Pharmacy:** | | | |
| GLAUCOMA |  |  |  |
| VISUAL CHANGE |  |  |  | **Pharmacy Address:** | | | |
| HEARING LOSS |  |  |  |
| GUM DISEASE |  |  |  | **NAME** | **STRENGTH** | **FREQUENCY** | **REASON FOR TAKING** |
| SINUS PROBLEMS |  |  |  |
|  |  |  |  |  |  |  |  |
| CLAUDICATION |  |  |  |
| BLOOD CLOTS IN LEGS (DVT) |  |  |  |  |  |  |  |
| THYROID DISEASE |  |  |  |
|  |  |  |  |  |  |  |  |
| COPD |  |  |  |
| ASTHMA |  |  |  |  |  |  |  |
| CHRONIC COUGH |  |  |  |
| COUGHING BLOOD |  |  |  |  |  |  |  |
|  |  |  |  |
| PEPTIC ULCER DISEASE |  |  |  |  |  |  |  |
| GERD (gastroesophageal reflux disease) |  |  |  |
| VOMITING BLOOD  BLOOD IN STOOL |  |  |  |  |  |  |  |
| DIARRHEA  GASTROINTESTINAL BLEEDING |  |  |  |
|  |  |  |  |
| CONSTIPATION |  |  |  |
| BLOOD IN URINE |  |  |  |  |  |  |  |
|  |  |  |  |
| MEN: ERECTILE DYSFUNCTION |  |  |  |  |  |  |  |
| PROSTATE DISEASE |  |  |  |
| WOMEN: GYNECOLOGICAL ISSUES |  |  |  |  |  |  |  |
|  |  |  |  |
| STROKE |  |  |  |  |  |  |  |
| TIA (mini stoke) |  |  |  |
| HEADACHES |  |  |  |  |  |  |  |
| SLEEP DISTURBANCES |  |  |  |
| DEPRESSION |  |  |  |  |  |  |  |
|  |  |  |  |
| JOINT PAIN/SWELLING |  |  |  |  |  |  |  |
| BACK PAIN |  |  |  |
| MUSCLE ACHES |  |  |  |  |  |  |  |
|  |  |  |  |
| UNEXPLAINED WEIGHT LOSS |  |  |  |  |  |  |  |
| FEVERS |  |  |  |
| LOSS OF APPETITE |  |  |  |  |  |  |  |
| UNEXPLAINED SWEATS |  |  |  |
|  |  |  |  |  |  |  |  |
| EASY BRUISING, NOSE OR GUM BLEEDING |  |  |  |
| BLOOD TRANSFUSIONS |  |  |  |  |  |  |  |
| ANEMIA |  |  |  |
| SWOLLEN LYMPH NODES |  |  |  | **USE ADDITIONAL SHEET OF PAPER TO LIST ANY OTHER MEDICATIONS** | | | |
|  |  |  |  |
| RASHES |  |  |  |
| SEASONAL ALLERGIES |  |  |  |