

Patient Registration Form ~ Please Print

Patient Name: _____ Date of Birth: ___ / ___ / ___

Social Security Number: _____ / _____ / _____ Circle One: Male / Female

Mailing Address

Street: _____

City, State *and* Zip Code: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

May we leave a voice and/or text message? Y N

Email: _____

Referring Physician: _____

Primary Care Physician: _____

Preferred Pharmacy: _____

Who should we contact in the event of an emergency:

Name: _____ Relationship: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Our office will bill your insurance. You are responsible for the deductible, share of cost, co-payment at the time of your visit, as well as any costs that may not be covered by your plan. If you do not have insurance, payment is due on the same date of service. Our staff is available if you have any questions.

I authorize payment of medical benefits be made directly to the physician provider for the services rendered. I authorize my doctor to release any medical or other information necessary to process claims with my insurance companies. I request payment of any government benefits to the party who accepts assignment. I authorize use of information from this form to bill my insurance companies.

MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARD OF CALIFORNIA

Signature: _____ Date: _____



EMPIRE VEIN & Vascular Specialists

Review of Systems

Name: _____ DOB: _____

Referring MD: _____ Primary MD: _____

Medication allergies: _____

Medications: (Name, Mg. Dose)

Family history of: Heart Disease Lung Disease Hypertension Kidney Disease

Social History of:

Tobacco: # of packs per day _____ #of year's smoked _____ Date quit _____

Alcohol: # of drinks per day _____ #of year's _____ Date quit _____

Are you currently pregnant, or plan on a pregnancy in the next six months? No Yes

Current Medical Illness and/or Past Major Surgeries: _____

Review of Systems: **Circle any that are appropriate**

Constitutional: Weight Loss, Fever, Fatigue, Weakness

Eyes: Double Vision, Loss of Vision, Blind Spots, Cataracts

Ear, Nose, Throat: Nosebleeds, Gum Disease, Hoarseness, Difficult Swallowing

Cardiac: High Blood Pressure, Chest Pain, Shortness of Breath, Murmurs, Previous Heart Attack, Heart Failure, Rheumatic Fever

Respiratory: Coughing up blood, Sputum Production, Emphysema, Wheezing Tuberculosis, Pneumonia

GI: Ulcer Disease, Heartburn, Liver Disease, Black Stool, Jaundice, Hepatitis

Musculo-Skeletal: Cramps with Walking, Varicose Veins, Joint Injuries, Arthritis, Swelling in Legs and/or Feet, Gout, Numbness

Skin: Rashes, Cuts, Cancers

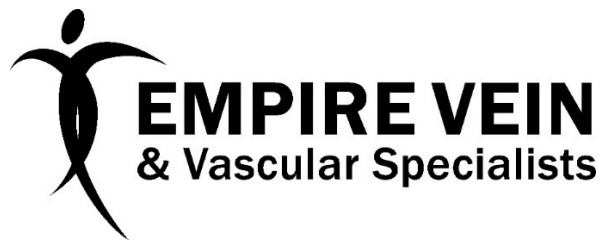
Neurological: Strokes, Dizziness, Tremors, Headache, Seizures, Transient, Blindness, and Loss of Arm or Leg Function, **Alzheimer's, Dementia**

Psychiatric: Anxiety, Depression, Sleep Disturbance, Hallucinations

Endocrine: Thyroid Disorder, Elevated Cholesterol, Diabetes

Hematological/Lymphatic: Prior Cancer, Prior Blood Transfusion, Bleeding Problems, Blood Clots

Allergy/Immunologic: Healing Problems, HIV Disease



Empire Vein & Vascular Specialists Cancellation Policy

Empire Vein & Vascular Specialists is committed to helping you manage and maintain your healthcare needs. When you schedule an appointment with one of our physicians or technicians that time is reserved exclusively for you to discuss and review your medical concerns. We do understand that on occasion, unforeseen circumstances do arise and the need to cancel your scheduled appointment may be necessary. If you know that you will be unable to keep your appointment, we ask you to show consideration by calling our office **24 hours in advance**. Providing our office with adequate notice will allow us to offer that appointment time to another patient.

Beginning January 1, 2014, the following no-show and/or late cancellation fees will be assessed:

A **\$25 charge** will be assessed for "no showing" or for failing to give 24-hour notice of the need to cancel all **routine appointments and ultrasound appointments**.

A **\$100 charge** will be assessed for "no showing" or for failing to give 24-hour notice of the need to cancel all **scheduled procedures**.

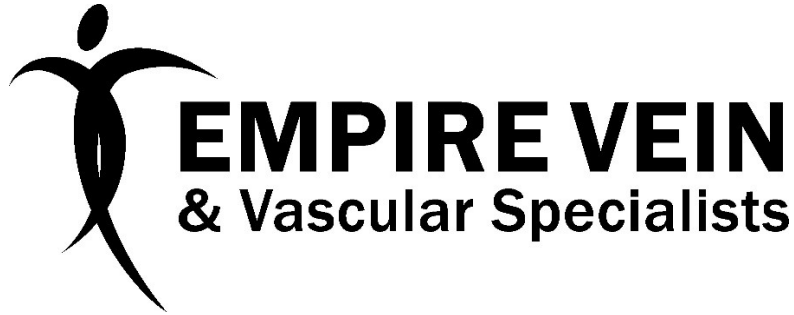
Please be advised that these **charges are not billable to your insurance** and will ultimately be the responsibility of the patient. All no show charges will need to be paid before your next appointment.

Your signature below indicates that you have read and agree to the above policy.

Patient Name

Date

Signature



MEDICAL RECORDS REQUEST

Patient Name _____

Date of Birth _____

The above patient is under the care of Empire Vein & Vascular Specialists.
Please forward the following information from their medical record:

- Consult Reports, Operative Reports, Discharge Summaries
- X-ray, CT, MRI, Ultrasound, and any other imaging studies

I hereby authorize the requested information contained in my medical record be forwarded to:

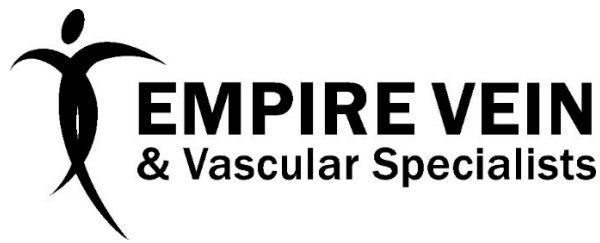
Empire Vein & Vascular Specialists

Rancho Mirage: 760-423-6273

Palm Springs: 760-832-6473

La Quinta: 442-324-0541

Patient Signature _____ Date _____



Patient Arrival Policy

At Empire Vein & Vascular Specialists, we are committed to providing high-quality healthcare services while respecting the time and schedules of all our patients. To ensure smooth operations and optimal patient care, we have implemented a Patient Arrival Policy with a **15-minute grace period** for late arrivals.

We understand that unforeseen circumstances may arise that could cause delays in your scheduled appointment. Therefore, we offer a 15-minute grace period for patients who arrive late for their scheduled appointment time. If you arrive within this grace period, we will make every effort to accommodate your appointment, but please be aware that there may be a need to adjust the appointment duration accordingly.

If you anticipate being late for your appointment, we kindly request that you contact our office as soon as possible. Our staff will do their best to assist you in rescheduling your appointment to a more convenient time.

We value the time of all our patients. Arriving on time ensures that everyone receives the attention and care they deserve. To avoid inconveniencing other patients, if you arrive more than 15 minutes late, we may need to reschedule your appointment to the next available time slot to ensure that our schedule remains on track for all patients.

Patient Signature

Date Signed