re·ju·ve·nate

verb \ri-`jü-və-nāte\: to make young or youthful again.
-renewal for the **skin**, **mind**, and **body**.

Date: _____

Patient History Form

Patient Name: _____DOB/ Age:_____/_____
Height/Weight ____'____"_____lbs

Problem(s) ____Varicose Veins __Spider Veins __Facial Veins __Other: _____

How long have you had this problem? _____

Do you have a family history of venous varicosities or blood clots? Y or N If so, whom _____

Do you have any history of medical conditions involving: (Please check what applies)

__Vision __Heart Disease __Arthritis __Migraines __Stroke __Hearing

__Digestion __Hepatitis __Teeth __Bowels __High Blood Pressure

__Swollen Glands __Urination __Diabetes __TIA __Lungs ____Joints

__Lipids __Asthma __Accidental Injury __Seizures __Kidney Disease

__Trouble with dental anesthesia __Cancer (type): _____

<u>For Varicose Vein patients:</u> (Please check what applies)

Right Leg:	**Left Leg:**
__Pain __Ulcer(s)	**__Pain __Ulcer(s)**
__Burning __Skin Damage	**__Burning __Skin Damage**
__Aching __Stinging	**__Aching __Stinging**
__Discoloration __Fatigue	**__Discoloration __Fatigue**
__Numbness __Heaviness	**__Numbness __Heaviness**
__Swelling __Blood Clots	**__Swelling __Blood Clots**

Does your symptoms interfere with daily living? Y N

If yes, how?_____

(ex: exercising, work, playing with children, housework or shopping)

Prior Vein treatment? Y or N

If yes, Date: _____ Where? _____ What was done? _____

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Please circle if using compression hosiery now: Over the counter 20-30 30-40 Time frame used? _____ to _____.

Have you had a prior venous ultrasound? If so, where? _____ When? _____

Have you used over the counter or prescription pain medication for varicose vein pain? Y or N

If so, what have you used? _____

Other Health issues: _____

_____

Current Medications: (Please list)

_____ _____

_____ _____

_____ _____

Allergies: (Please list)

_____ _____

_____ _____

Social History:

Occupation: _____

Activity Level: (Please circle) HIGH MODERATE LOW

Do you use tobacco products: Y or N If so, how much? _____ How often? _____

Do you drink alcohol products? Y or N If so, how much? _____ How often? _____

Family history of health problems? _____

_____

Reproductive History: (Please check if applies)

___Pre-Menopausal ___ Post-Menopausal ___ Birth Control Pills ___Hormone Therapy

Number of pregnancies: _____

Physician Signature: _____ Date: _____

Kettering Cardiothoracic & Vascular Surgeons Inc.

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Peter Pavlina, M.D.
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***Karl Borsody, M.D.**
** A partner of Kettering Physician Network*

Bruce Rank, D.O.
Jennifer Schafer, PA-C

NOTICE OF CONSENT AND FINANCIAL RESPONSIBILITY PATIENT ACKNOWLEDGMENT

I hereby authorize the Physician/Physician group above to provide treatment and/or tests to me. I hereby authorize release of information to my insurance companies as applicable. I understand I am responsible for my bill. I authorize payment directly to my Physician/Physician group. I authorize use of this form on all of my insurance submissions. I authorize this practice to act as my agent to help me secure payment from my insurance companies on all services not designated as cosmetic or medical supplies such as compression hosiery, skin care products and gloves. Of note, Kettering Cardiothoracic and Vascular Surgeons Inc. owns the ultrasound vascular lab located in suite 5650. If an ultrasound is ordered that can be done at our own lab, we will schedule you there. However, you can choose to have this test at any lab that you choose. If you wish to do that, please let our scheduler know at the time of booking. We have a list of 3 other independent labs in our area that perform these same tests that we can share with you upon request.

I hereby authorize release of medical records or copies of such, and request that they be mailed or faxed to Kettering Cardiothoracic and Vascular Surgeons, Inc. to carry out treatment, payment, and healthcare operations. I also authorize release of my medical records or copies of such from Kettering Cardiothoracic and Vascular Surgeons, Inc. and/or Rejuvenate to other healthcare providers to carry out treatment, payment and healthcare operations.

SIGNATURE:_____**DATE:** _____

NOTICE OF PRIVACY POLICY PATIENT ACKNOWLEDGMENT

The Notice of Privacy Practices describes your rights in regard to your health information, the possible uses of your health information, and how we must protect the confidentiality of your health information.

THIS IS NOT A CONSENT. BY SIGNING BELOW YOU ARE ONLY STATING THAT WE HAVE OFFERED TO PROVIDE YOU WITH A COPY OF OUR NOTICE OF PRIVACY PRACTICES. IF YOU WISH TO RECEIVE A COPY OF THIS FORM, ASK THE STAFF MEMBER WHO IS ASSISTING YOU.

We encourage you to carefully read the full Notice.

I have been given the Kettering Cardiothoracic and Vascular Surgeons, Inc.'s/Rejuvenate Notice of Privacy Practices:

Printed Patient Name: _____

Signature: _____ **Date:** _____

Relationship to Patient (If patient unable to sign): _____

May we leave a message on an answering machine and/or with a family member: Y N

Witness: _____ **Date:** _____