D Number: _____

stric
SOUTH TEXAS RADIOLOGY
IMAGING CENTERS

PATIENT INFORMATION (PLEASE PRINT)

LAST NAME	FIRST NAME	MIDDLE INITIAL

MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE

HOME PHONE #	CELL PHONE #	WORK PHONE #	DATE OF BIRTH	SEX	SS#
( ) -	( ) -	( ) -	/ /	☐M ☐F	/ /

EMAIL	REFERRING PHYSICIAN	EXPLAIN CURRENT SYMPTOM(S) FOR THIS EXAM(S)

INSURANCE INFORMATION
A COPY OF YOUR INSURANCE CARD AND/OR PAYMENT WILL BE REQUIRED

1. PRIMARY INSURANCE	POLICY HOLDER	SS#
☐ SELF ☐ SPOUSE ☐ OTHER ☐ MOTHER ☐ FATHER	BILLING ADDRESS	
	POLICY ID#	GROUP / PLAN #

MEDICARE PATIENT ONLY: Are you currently participating in a Clinical Research Trial? ☐YES ☐NO

2. SECONDARY INSURANCE	POLICY HOLDER	SS#
☐ SELF ☐ SPOUSE ☐ OTHER ☐ MOTHER ☐ FATHER	BILLING ADDRESS	
	POLICY ID#	GROUP / PLAN #

3. WORKERS' COMPENSATION		
EMPLOYER	EMPLOYER ADDRESS	WORK PHONE # ( )
W/C INSURANCE CARRIER	W/C INSURANCE CARRIER ADDRESS	CLAIM #
DATE OF INJURY	ADJUSTER'S NAME	ADJUSTER'S PHONE # ( )

INSURANCE ASSIGNMENT
I hereby consent to the release of information to my insurance carrier regarding my treatment at South Texas Radiology Imaging Centers (STRIC). I further authorize payment to be made directly to STRIC for any insurance benefits to which I am entitled.

STATEMENT OF FINANCIAL RESPONSIBILITY
I understand and agree that I am financially responsible for any and all charges for services rendered by STRIC regardless of the existence of a health plan or health insurance and assignment of insurance benefits. Many insurance companies have additional stipulations that may affect your coverage. I understand I am responsible for any amounts not covered by my insurer. If my insurance carrier denies any part of my claim, I will be responsible for the balance. STRIC bills secondary insurances only as a courtesy. Any balance not paid by secondary insurance will become my responsibility to pay.

RELEASE OF STRIC MEDICAL RECORDS TO HEALTH CARE PROVIDERS
I hereby consent and authorize STRIC to release any and all information in my medical records to my physician(s) and other health care providers involved in providing care to me.

RELEASE OF MEDICAL RECORDS TO STRIC
I hereby request and authorize my health care provider(s) to release to STRIC: medical records, x-ray films, reports and pathology results as needed in assisting STRIC in providing my medical consultation, care and/or treatment.

OUT OF NETWORK INSURANCE - ACKNOWLEDGEMENT OF POTENTIAL LIABILITY
I am aware that the STRIC facility where I am having services performed is not considered to be "In Network" with the third party insurance plan that provides my payment coverage. I acknowledge that the insurance plan may, therefore, provide benefits at the "Out of Network" level. I understand that I am personally responsible for paying any remaining balance due for these services. _____ Initials

X _____ _____
Signature of Patient/Legally Authorized Person/Financially Responsible Party — Date

_____ _____
PLEASE PRINT NAME — SS# (IF OTHER THAN PATIENT)

PATIENT VENOUS HISTORY

Patient name: _____ Date: _____Age: _____
Email address: _____

Medication List:

Name of prescribed medication, supplement, or over-the counter medication	Dosage amount	Frequency	Prescribed by (name of physician)

Venous History: Check vein problem, location and symptoms of which you are experiencing:

Varicose Veins Right leg ☐ Left leg ☐ or Both legs ☐
Spider Veins Right leg ☐ Left leg ☐ or Both legs ☐
Other Vein Problems (e.g. hands, feet, face, chest) Location _____

☐ Ache
☐ Bleeding
☐ Heaviness
☐ Itching
☐ Leg Cramps
☐ Leg/Foot Swelling
☐ Numbness
☐ Pain
☐ Pressure
☐ Phlebitis
☐ Restless Legs
☐ Throbbing
☐ Tingling
☐ Tired Legs
☐ Ulcer
☐ Redness or Discoloration
☐ Prolonged sitting or standing aggravate symptoms

How long ago did your symptoms start? _____

Did your varicose veins begin with or become worse with? ☐Physical trauma ☐Pregnancy ☐Family History

Do your legs feel better when you elevate them? _____

Have you ever worn **prescribed compression hose**? Do your legs feel better when wearing them? _____

Do you have any contact allergies (example: Latex)? _____

Have you ever taken an aspirin, Tylenol, Aleve, Advil, Motrin, Ibuprofen, Naproxen, etc. for your symptoms? _____

Have you ever had treatment for your veins? ☐Sclerotherapy ☐Ligation/Stripping. When? _____

Most patients have lived with the above symptoms for years and do not even realize they are experiencing them and how it affects their lives; however, we need to know how these symptoms affect at least 2 activities of your daily life: (walking, standing, playing with your children/grandchildren, shopping, etc). When does the pain start?

_____

_____

I have read the pamphlet on EVLT and varicose veins and am aware of the anatomy and physiology of veins, potential insurance requirements, possibility of having to treat more than one vein (4 to 6 weeks apart), and potential risks of procedures and expectations of recovery. I consent to the taking of photographs for use regarding my care as well as for scientific or educational purposes.

Signature: _____ Date:_____

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Medical History

Print Name_____ Date _____ Age _____

Email Address: _____Emergency Contact:_____

Please check **Y** if you've ever experienced any of the following and **C** if you are currently experiencing any of the following:

Y	C		Y	C		Y	C	
☐	☐	Anemia/Blood disorder	☐	☐	Diabetes	☐	☐	Problems that limit walking or exercise
☐	☐	Anxiety	☐	☐	Dialysis	☐	☐	Breastfeeding
☐	☐	Arthritis/Orthopedic	☐	☐	Endometriosis	☐	☐	Stroke/TIAs
☐	☐	Asthma/emphysema	☐	☐	Excessive Scarring (Keloids)	☐	☐	Thyroid disorder
☐	☐	Atrial Fibrillation	☐	☐	Excessive Fear of Needles	☐	☐	Varicose veins
☐	☐	Back problems	☐	☐	Frequent migraines	☐	☐	Any other significant medical or vein problems (e.g. headaches, digestive problems, urinary problems)
☐	☐	Bipolar disease	☐	☐	Frequent urination			
☐	☐	Bleeding Problems	☐	☐	Glasses/Contacts			
☐	☐	Skin Cancer	☐	☐	Heart disease			
☐	☐	Other Cancer_____	☐	☐	Heart catheterization/Stents			
☐	☐	Chemo/Radiation	☐	☐	Heart valve disorder			**Medications**
☐	☐	Chest pain/heart attack	☐	☐	Hepatitis	☐	☐	Do you take a blood thinner medication? (e.g. Aspirin, Plavix, Warfarin, Coumadin, Aggrenox)
☐	☐	Chronic constipation	☐	☐	High blood pressure			
☐	☐	Chronic Obstr Pulm Disease	☐	☐	Lung/Breathing			
☐	☐	Cirrhosis	☐	☐	Lupus			Please list any over-the-counter medications:_____
☐	☐	Clotting	☐	☐	Metal Implants			
☐	☐	Deep Vein Thrombosis (DVT)/Blood Clots	☐	☐	Phlebitis			
			☐	☐	Pigmentation problems			
☐	☐	Defibrillator/Pacemaker	☐	☐	Poor wound healing			
☐	☐	Depression	☐	☐	Pregnant			
☐	☐	Double vision			Number of pregnancies____			

Which physicians are currently treating you? _____

May we contact them for medical records pertinent to the condition you are being evaluated for today? ☐No ☐Yes_____(Initials)

Do you smoke? ☐Never ☐No ☐Yes If yes, how many packs/day ____ How many years? ____ When did you stop smoking? ___

Do you drink alcohol? ☐Never ☐No ☐Yes If yes, how many glasses/day/week/month _____ How many years? _____

Previous Surgeries:

Name of surgery	Date of surgery	Name of surgery	Date of surgery

Allergies:

☐ No known allergies

☐ I am allergic or sensitive to: _____What happens?_____

☐ I develop a rash with use of tape, Band-Aids, latex items

Family Medical History

	Parent History			Grandparent or Sibling History		
Health conditions	Specify Father/Mother	Current age:	Age at death___ Cause (es) of death?	Health conditions	Current age:	Age at death____ Cause (es) of death?

I declare the information provided is true and accurate to the best of my knowledge and will be made a part of my medical record.

Signature of Patient (Parent/Guardian)_____ Date _____

Disclosures to Families and Loved Ones Patient Initials _____

I agree to the release of my PHI to the following person(s) _____

We will comply with any patient's request for us to share their personal health information with family member(s) and other designated person(s). We will comply with an oral request as long as: (1) any oral request is noted in the patient's record; (2) the patient is competent to make this decision; and (3) the patient has not revoked that request.

☐ Permission to Photograph Patient Initials _____

I authorize the staff of the Interventional Radiology Clinic staff to photograph me and affected parts of my body and to include the photographs in my medical record. I agree to the release of the photographs if requested by my insurance company for establishing medical necessity of prescribed treatment.