New patient information form ***Name*** _____

Reason for evaluation: _____

My symptoms include: ❑ pain ❑ discomfort ❑ aching ❑ leg heaviness ❑ leg fatigue ❑ leg swelling ❑ leg cramps ❑ burning ❑ itching ❑ restless legs ❑ bleeding from a vein ❑ other _____

What kind of activities do your symptoms impact? ❑ standing ❑ sitting ❑ walking ❑ running ❑ exercise ❑ work duties ❑ house chores ❑ cooking ❑ dressing ❑ bathing ❑ shopping ❑ other _____

Symptoms worsened by: ❑ standing ❑ menstruation ❑ pregnancy ❑ heat ❑ walking ❑ exercise ❑ other _____

Symptoms helped by: ❑ leg elevation ❑ compression hose ❑ walking ❑ exercise ❑ other_____

Have you recently experienced? ❑ fevers ❑ swollen lymph glands ❑ visual disturbances ❑ nosebleeds ❑ headaches ❑ migraine ❑ seizures ❑ chest pain ❑ heart racing ❑ fainting ❑ swollen ankles ❑ wheezing ❑ shortness of breath ❑ heartburn ❑ black or bloody stools ❑ blood in urine ❑ current pregnancy ❑ planned pregnancy in near future ❑ actively nursing ❑ pelvic pain ❑ pelvic varicose veins ❑ joint pain ❑ low back pain ❑ sciatica ❑ anxiety ❑ slow-healing leg wounds ❑ ankle area skin rashes ❑ anemia

What other medical problems do you have? _____

Have you ever had: ❑ venous blood clots ❑ pulmonary embolism (blood clots to the lung) ❑ leg injury ❑ leg fractures ❑ leg surgery ❑ leg immobilization ❑ leg ulcer

Have you ever had <u>any</u> vein evaluations or treatments? ❑ no ❑ leg ultrasound ❑ vein surgery ❑ laser ablation ❑ sclerotherapy ❑ other _____

What medications do you take regularly? _____ ❑ none

What medication allergies do you have? _____ ❑ none

Are you allergic to latex, adhesives, Band aids, fake nails, or fake eyelashes? ❑ no ❑ yes _____

How many times have you been pregnant? _____ ***How many children do you have?*** _____

Do you experience the formation of excess scar tissue? ❑ no ❑ yes _____

Do you get lightheaded or faint from needles or medical procedures? ❑ no ❑ yes _____

Have you ever had a bad reaction to a local anesthetic or a sedative? ❑ no ❑ yes _____

Occupation: _____ ❑ homemaker ❑ retired

Do you exercise regularly? ❑ no ❑ yes If yes, preferred exercise _____

Do you smoke? ❑ no ❑ yes If yes, _____ packs per day

Level of daily activity: ❑ active ❑ limited activity ❑ sedentary ❑ walker or cane or wheelchair

Is there a family history of venous blood clots? ❑ no ❑ yes _____

Is there a family history of varicose veins? ❑ no ❑ yes _____

Signature: _____ Date: _____/_____/_____

Eric Mowatt-Larssen, MD

243 El Dorado Street #200, Monterey, CA 93940
1260 S. Main Street #202, Salinas CA 93901
Phone (831) 646-8346

PATIENT POLICIES

Consent for photography

I consent to allow taking pictures of my veins and vein symptoms. These pictures will be in my medical chart and will be used to follow the progress of my treatment and/or sent to my insurance company to document my vein disease if necessary. The pictures will not be used for any other purpose (such as scientific publication or marketing) unless you specifically allow it in a separate consent form. At no time will you be identified by name or likeness, and your identity will be protected as much as possible. Initials__

Cancellation and late policies

Our healthcare can best be described as low volume and high quality. Each appointment time involves highly trained medical specialists and state-of-the-art equipment, and has been specifically reserved for you. We ask that you call two days in advance to reschedule or cancel your appointment. With appropriate cancellation notice we can allow another patient to take your appointment time.

If we do not receive notification, you may be charged a cancellation fee of $250 for a missed thermal ablation appointment, or $50 for any other appointment. These charges are not covered by your insurance carrier.

We strive to remain on time for our patients in recognition of people's busy schedules. If you are more than 15 minutes late, we will ask you to reschedule your appointment. Initials__

Use or protected health information

I have been provided an opportunity to review the Notice of Privacy Practices and I hereby consent to the use of disclosure of my individually identifiable health information in order to carry out evaluation, treatment, payment or health care operations by Eric Mowatt-Larssen, MD. Initials__

Consent to medical treatment

I consent to medical treatment by Eric Mowatt-Larssen, MD. Initials__

Statement of financial responsibility

I hereby assign, transfer and set over my rights to any insurance reimbursement benefits to Eric Mowatt-Larssen, MD. I authorize the release of any medical information needed to determine these benefits.

I understand that I will be held financially responsible for any and all services provided by Eric Mowatt-Larssen, MD, whether they are covered by insurance or not. If your account is sent to collections, you will be responsible for legal fees associated with collections. I further understand that I may be responsible for determining if my insurance policy covers the services of Eric Mowatt-Larssen, MD. Initials__

I understand the above policies

_____ _____

Patient Date

Eric Mowatt-Larssen, MD
243 El Dorado Street #200, Monterey, CA 93940
1260 S. Main Street #202, Salinas CA 93901
Phone (831) 646-8346

Patient Contact Information

Name _____

Birthdate: _____ / _____ / _____

Address_____

City_____State_____ Zip Code _____

Preferred method to contact you_____

Cell Phone_____Home Phone_____

May we leave an appointment message on your preferred phone voicemail? ❑ Yes ❑No

Insurance_____

Social Security: _____-_____-_____

Emergency Contact: _____Relationship to You: _____

Emergency contact phone: _____

We can discuss your treatment with him / her? ❑Yes❑No

Primary Care Physician_____

May we discuss your care with him/her? ❑Yes❑No

How did you learn about us? ❑Friend ❑Physician ❑Herald ❑Phone Book ❑CHOMP ❑Other

Signature: _____Date: _____ / _____ / _____