Patient Name: _____ Birth Date: _____/_____/_____ Date: _____
month day year

Race **(Circle One):** American Indian/Asian/African American/Hispanic/Pacific Islander/White/Decline

Ethnicity **(Circle One):** Hispanic or Latino /Not Hispanic or Latino/ White / Decline Sex: Male / Female

Address: _____ Marital Status: S / M / D / W

City: _____ State: _____ Zip Code: _____

Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

E-Mail: _____ Written Contact Preference: By Mail / By E-mail

Employment Status: Employed / Unemployed / Student / Retired Occupation: _____

Emergency Contact: _____ Telephone: (_____)_____
(Relationship to you)

**Do you have health insurance?** □ Yes □ No
We will make copies of your cards if you would like us to check your benefits.

Are you the primary subscriber? □ Yes □No

If no, what is the primary subscriber's first & last name? _____ Relation: _____

Primary subscriber's Date of Birth: _____

**How did you hear about us?**

□ TV □ Internet Search □ Yelp □ Facebook □ Instagram □ Email □ Magazine or Newspaper

□ Family or Friend :(name) _____ □ You are a previous patient

□ Doctor: (Name of doctor) _____ □ Event: (name or location of event) _____

□ Follow up call from our office □ Other: _____

**What is the reason for your Visit?** (ex. Pain in Legs, varicose veins, unwanted fat, wrinkles, brown spots, etc.)

_____

## Please put a check mark next to the areas of concern / interest:

___Coolsculpting/Unwanted Fat
___Spider Veins/Varicose Veins
___Facial Veins
___Broken Capillaries
___Rosacea/ Facial Redness
___Mole Removal
___Free Skin Analysis
___Fine lines and wrinkles
___Pellevé and/or CO2 Laser
___Chemical Peel
___Scar Revision
___Facial Contouring
___Voluma (Cheek enhancement)
___Botox
___Juvederm (Facial filler)
___Latisse
___Acne Treatment
___Skin Toning or Pore Size Reduction
___Dry, tired, uneven or rough skin
___Facials/Microdermabrasion/Peel
___Skin Care Advice or Products
___Eyelash length & fullness
___Blotchy skin
___Brown Spots/Age Spots/Freckles

**GENERAL HISTORY**

**Do you have a history of:**

| | YES | NO |
|---|---|---|
| DVT (deep vein clot) | □ | □ |
| Varicose Veins | □ | □ |

**Do you *currently* have any of the following?**

| | YES | NO |
|---|---|---|
| **Constitutional** | | |
| Chills | □ | □ |
| Fever | □ | □ |
| Weight Loss | □ | □ |
| **Head** | | |
| Dizziness | □ | □ |
| Headaches | □ | □ |
| Head Injury | □ | □ |
| **Respiratory** | | |
| Asthma | □ | □ |
| Cough | □ | □ |
| Short of Breath | □ | □ |
| **Cardiovascular** | | |
| Chest Pain | □ | □ |
| High Blood Pressure | □ | □ |
| Pain in Leg(s) | □ | □ |
| Heart Murmur | □ | □ |
| Swelling in Leg or Ankle(s) | □ | □ |
| **Musculoskeletal** | | |
| Arthritis | □ | □ |
| Gout | □ | □ |

| | YES | NO |
|---|---|---|
| **Other Conditions:** | | |
| Diabetes | □ | □ |
| Heart Disease | □ | □ |
| High Cholesterol | □ | □ |
| Obesity | □ | □ |
| Hyperthyroid (high thyroid) | □ | □ |
| Hypothyroid (low thyroid) | □ | □ |
| Liver Disease | □ | □ |
| Hepatitis B or C | □ | □ |
| Anemia | □ | □ |
| Kidney Disease | □ | □ |
| Bleeding Disorder | □ | □ |
| Lupus | □ | □ |
| Keloid Scaring | □ | □ |
| Pacemaker | □ | □ |
| Cold Sores | □ | □ |
| HIV or AIDS | □ | □ |
| Are you currently Pregnant? | □ | □ |
| Are you currently Breastfeeding? | □ | □ |
| Use birth Control | □ | □ |
| Hernias (location) _____ | □ | □ |

Other: _____

_____

**Medication Allergies:** □ None _____

**Medications You Are Currently Taking (please list the strength if known):** □ no meds taken

_____

_____

**Family History:** Does/Did anyone in your immediate family have varicose veins? □ **Yes** □ **No**

**If yes, please choose:** □ Mother □Father □Grandmother □ Grandfather □ Brother □ Sister

If you checked any of the family member boxes above, are they □ Living or □ Deceased?

**Have you received a Flu or Pneumonia Shot?** □ No □Yes If yes, Date received:_____

**What was the name of the Immunization you received?** _____

Do you Smoke? **(circle one)** YES NO

Do you Drink? **(circle one)** YES NO

**Previous Surgeries**: □ No prior surgeries _____

_____

**Height:**_____ **Weight:**_____

# V E I N S

***PLEASE BE SURE TO COMPLETE THE SYMPTOMS SECTION***

****NOTE: All services must be considered medically necessary with <u>significant symptoms</u> & <u>prior use of compression hose</u> in order to bill your insurance.**

**How Many Years Have You Noticed A Problem With Varicose And/Or Spider Veins?** _____

***<u>SYMPTOMS</u>:***

❒ Burning ❒ Itching ❒ Tingling ❒ Cramping

❒ Heaviness ❒ Leg Fatigue ❒ Leg Rash ❒ Pain/Discomfort

❒ Ulcer ❒ Swelling of ankle(s) ❒ Restless Legs

❒ *Cosmetic/don't like the way they look (insurance **DOES NOT** cover this symptom)*

❒ Other Explain: _____

**Have you tried wearing compression hose or taking OTC medications to alleviate your symptoms?** (Insurance needs to know this in order for them to either approve or deny your treatments.)

❒ Yes ❒ No

**Have You Ever Been Treated For Varicose And/Or Spider Veins?** ❒ Yes ❒ No

If Yes, When _____ By Whom? _____

What Method? ❒ Stripping ❒ Ligation ❒ Surface Laser ❒ Sclerotherapy(injections)

❒ EVLT/RFA ❒ Unknown ❒Other:_____

# PAYMENT GUIDELINES

Thank you for choosing Dr. Greenberg for your care.
The following are our established guidelines that will be followed in resolving all claims for services rendered by our physicians and staff.

Private Pay/ No Insurance: Payment is due at the time of service. Check-ups are $25. Payment plans are always available.

| | |
|---|---|
| Medicare: | Dr. Greenberg is contracted with Medicare. Our contract requires us to bill Medicare for your initial consultation. If you have a supplemental insurance, depending on your plan, they may cover the remaining 20% that Medicare does not cover. You are responsible for any balances AND deductibles that your supplemental does not pay or cover. Patients *without* a supplemental insurance will be responsible for the remaining 20% on all services provided. |
| PPO: | Dr. Greenberg is IN-NETWORK with most Anthem (CA)PPO & Blue Shield (CA)PPO plans. Our contract requires us to bill Anthem (CA) and/or Blue Shield (CA) for your initial consultation and all subsequent visits. You are responsible for any deductibles AND balances not covered by your insurance company.<br><br>Dr. Greenberg is out-of-network for all other PPO's. Because we are out-of-network, we collect for the services ahead of time. We will bill your insurance company as a courtesy and they will refund you once all deductibles are met and/or if coverage is available. Payment plans are always available. |
| Anthem of Covered CA: | We are out of network but you may request from your insurance company an Out Network Referral to get in-network coverage. |
| HMO: | We do not accept. |

****NOTE:**
**All services must be considered medically necessary with significant symptoms in order to bill your insurance.****

There is a $25 fee for copies of any medical records.

**Effective Feb. 1st 2014:** Due to the number of returned checks we have received, *we are no longer accepting personal checks.*

*****We are a FEE FOR SERVICE facility. Therefore, payment is due BEFORE services are rendered.*****

| | |
|---|---|
| Patient Name Date | **Patient Signature** |
| Witness Name Date | Witness Signature |