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: _____(We may ask for SSN also)

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
___Hand Veins
___Mole Removal
___Dry, tired, uneven or rough skin
___Rosacea/ Facial Redness
___ Belotero ("Smoker Lines")
___Botox / Xeomin (Wrinkle Reducers)
___Juvederm (Facial filler)
___Radiesse / (Volumizing filler)
___Scar Revision
___Skin Toning or Pore Size Reduction
___Brown Spots/Age Spots/Freckles
___Hand Rejuvenation

GENERAL HISTORY

Height:_____ **Weight:**_____

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:_____

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

Previous Surgeries: □ No prior surgeries _____

_____

V E I N S

PLEASE BE SURE TO COMPLETE THE SYMPTOMS SECTION IF APPLICABLE

****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? _____

SYMPTOMS:

❒ 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 (higher chance of insurance covering your treatments) ❒ No (insurance will not cover any treatment)

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. Sanford J. Greenberg, M.D. 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 upon check in. Check-ups are $25. Payment plans are always available. Care Credit is accepted.
Medicare As Primary:	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. Medicare only covers medically necessary vein treatments.
PPO:	Dr. Greenberg is IN-NETWORK with most Anthem (CA) PPO, Blue Shield PPO, Cigna & Aetna plans. Our contracts require us to bill your insurance company for your initial consultation and all subsequent visits. You are responsible for any deductibles, co-payments, co-insurances AND balances not covered by your insurance company. PPO insurance companies only cover medically necessary vein treatments. 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.
Covered CA:	We are out of network with most plans, but you may request from your insurance company an Out of Network Referral to get in-network coverage.
HMO:	We do not accept. You will be considered a private pay patient.

****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**	**X**	**Patient Signature**
Witness Name	Date		Witness Signature