Vein Center OF IDAHO

4519 Enterprise Way #205
Caldwell, ID 83605
Telephone: (208)454-4976
Fax: (208) 454-4997

3581 E Overland Road
Meridian, ID 83646
Telephone (208) 402-4467
Fax (208) 321-8626

PLEASE COMPLETE ALL HIGHLIGHTED AREAS

Patient Name: _____

Nickname: _____

Date of Birth: _____

Sex: _____

Soc Sec #: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Country: _____

Marital Status: _____

Pharmacy: _____

Guardian: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Contact Email: _____

Emergency Contact: _____

Emergency Phone: _____

Primary Care MD: _____

Referring Physician: _____

How did you hear about us? _____

_____

_____

HIPAA CHOICES:

Did you receive a copy of the HIPAA Notice? Yes_____ No_____

Allow Calls to Home: Yes_____ No _____

Allow Postal Mail: Yes_____ No _____

Allow Calls to Cell: Yes_____ No _____

Allow Voice Message: Yes_____ No _____

Who may we leave a message with?

_____

Occupation: _____

Employer: _____

(Leave Blank if not applicable)

Employer Address: _____

City: _____

State: _____ Zip Code: _____

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PLEASE COMPLETE ALL HIGHLIGHTED AREAS

Primary Insurance Provider: (Please provide a copy of your card)

Insurer: _____

Plan Name: _____

Effective Date: _____

Policy Number: _____

Group Number: _____

Co Pay: _____

Subscriber Employer: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Subscriber: _____

(If self-do not complete the following lines.)

Relationship: _____

Date of Birth: _____

Social Sec #: _____

Sex: _____

Subscriber Address: _____

City: _____

State: _____

Zip Code: _____

Subscriber Telephone #: _____

Secondary Insurance Provider: (Please provide a copy of your card)

Insurer: _____

Plan Name: _____

Effective Date: _____

Policy Number: _____

Group Number: _____

Co Pay: _____

Subscriber Employer: _____

Address: _____

City: _____

State: _____

Subscriber: _____

(If self-do not complete the following lines.)

Relationship: _____

Date of Birth: _____

Social Sec #: _____

Sex: _____

Subscriber Address: _____

City: _____

State: _____

Zip Code: _____

Subscriber Telephone #: _____

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PLEASE COMPLETE ALL HIGHLIGHTED AREAS

Tertiary Insurance Provider: (Please provide a copy of your card)

Insurer: _____

Plan Name: _____

Effective Date: _____

Policy Number: _____

Group Number: _____

Co Pay: _____

Subscriber Employer: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Subscriber: _____

(If self-do not complete the following lines.)

Relationship: _____

Date of Birth: _____

Social Sec #: _____

Sex: _____

Subscriber Address: _____

City: _____

State: _____

Zip Code: _____

Subscriber Telephone #: _____

Medical Information Release and Assignment of Benefits:

Dr Christopher Malcom DO and Joseph Robinson, PA are hereby authorized to furnish information to insurance carriers concerning my illness and treatments, and to collect all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered or paid by insurance. I am also responsible for any deductible, copay and/or co-insurance at the time services are rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. I have the right to revoke this authorization at any time in writing.

Patient Signature: _____ **Date:** _____

Parent or Guardian Signature: _____ **Date:** _____

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Meridian location

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Meridian, Id 83642

Tel: 208 402-4467

Fax: 208 321-8626

Caldwell location

4519 Enterprise Way

Caldwell, Id 83605

Tel: 208 454-4976

Fax: 208 454 4997

Patient History

Patient Name:_____ **DOB:**_____

Patient is here for:_____

Chief complaint: _____

_____

Which leg: _____**Right** _____**Left** _____**Both** **How long**_____

Previous Venous treatments: _____

Social History: **Alcohol:** _____**Never** ____**Rare** _____**Occasional/Social** _____**Daily**

Tobacco Use: _____**Never** _____**Quit > 10 yrs** ____**Quit 1-10 yrs** ____**Quit <1yr**

_____**Currently using**

Past Medical History: _____

_____

Current Medications: _____

_____

Allergies: _____

Vital signs: **HT:** _____ **WT:**_____ **BP**_____/_____**Pulse:**_____ **Resp:**_____
SAO2:_____

G: _____ **P:**_____ **HX of DVT or PE:** _____**No** ____**Yes** **How long ago:**_____

Vein Center OF IDAHO

3581 W Overland Road

Meridian, ID 83646

(208) 402-4467

4519 Enterprise Way, Ste 205

Caldwell, ID 83605

(208) 454-4976

If you are receiving sclerotherapy treatment at your appointment, please do not take any anti-inflammatories (ibuprofen, aspirin, aleve) the day of your appointment. Avoid wearing flip flop type sandals as you will be required to wear compression stockings post treatment.

Thank you in advance for your cooperation. Please feel free to call with any questions or concerns regarding your upcoming appointment.

Thank you,

Vein Center of Idaho staff

Vein Center OF IDAHO

Cancellation/No Show Policy for Appointments

Our goal at the Vein Center of Idaho is to provide quality individualized medical care in a timely manner. No-shows, late shows and cancellations inconvenience those who need access to medical care. We would like to notify you of our policy regarding missed appointments.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of a consultation or treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least **24 hours** in advance. Appointments are in high demand and your early cancellation will allow another patient access to timely medical care.

How to Cancel Your Appointment

To cancel your appointment please call **208 454-4976 or 208 402-4467**. If you do not reach the receptionist, you may leave a detailed message on our voice mail to include your name and phone number.

Late Cancellations: A cancellation is considered to be late when the appointment is cancelled without a **24 hour** advance notice.

Late Cancellation/No Show Policy for Provider Appointments: A no show or late cancellation will result in the following fees: Surgical services **$150** and all other services **$25**; these fees will not be billable to or be covered by your insurance.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Vein Center OF IDAHO

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____
to release healthcare information of the patient named above to:

Vein Center Of Idaho
3581 E. Overland Rd
Meridian, Idaho 83642
Telephone 208-402-4467 Fax 208-321-8626

Vein Center of Idaho
4519 Enterprise Way Ste 205
Caldwell, Idaho 83605
Telephone 208-454-4976 Fax 208-454-4997

This request and authorization applies to:

___ Healthcare information related to the following treatment, condition, or dates: _____

_____

___ All healthcare information

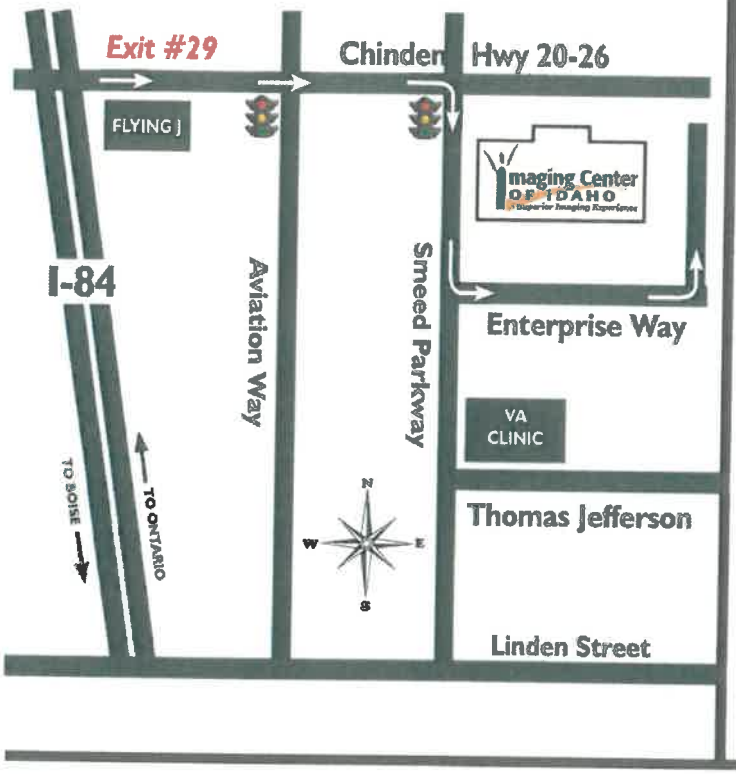
___ Other: _____

Patient Signature: _____ Date _____

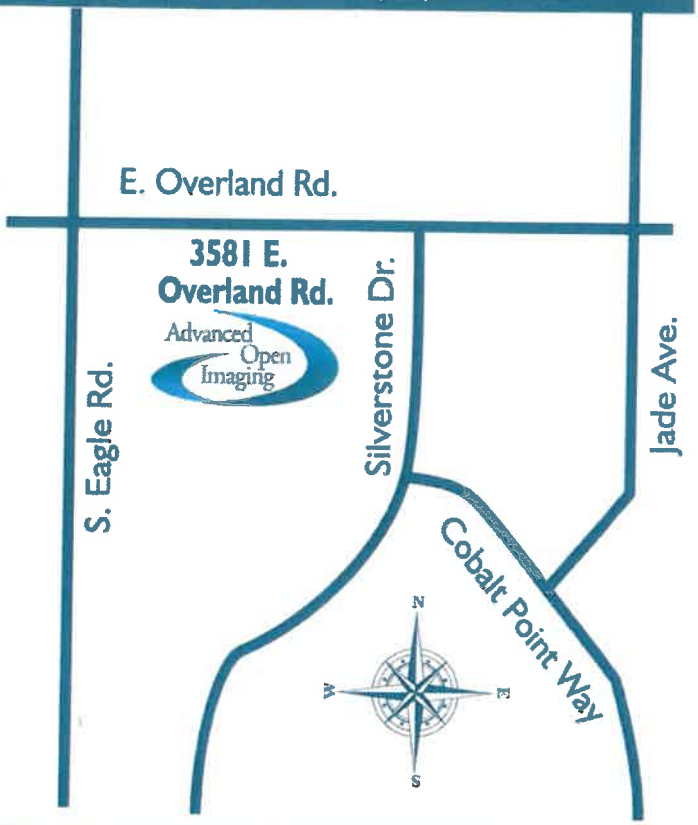
Parent or Guardian Signature: _____ Date _____

Authorized facility Signature _____ Date _____

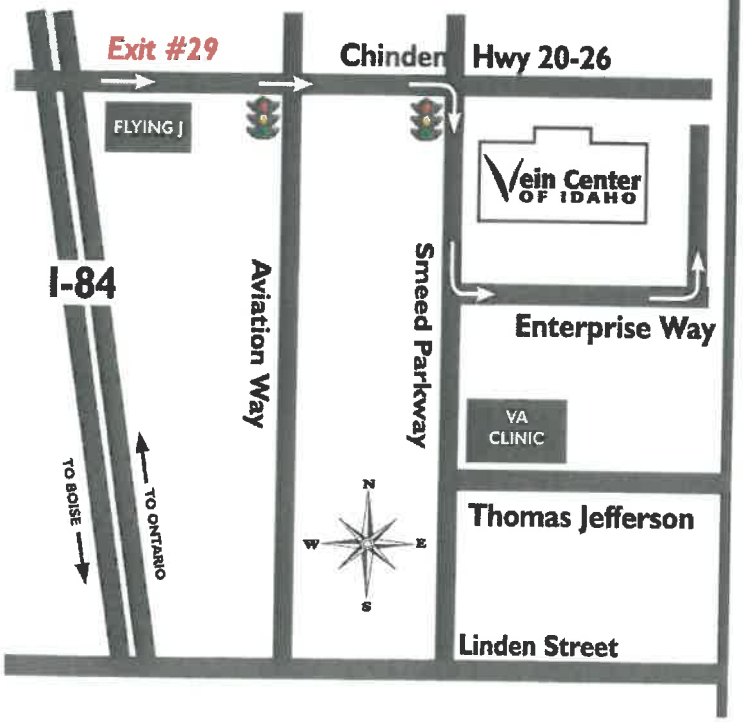
IMAGING CENTER OF IDAHO
4519 ENTERPRISE WAY · CALDWELL 83605
PHONE: 208-454-0742 · FAX: 208-454-2341



ADVANCED OPEN IMAGING
3581 E. OVERLAND RD. · MERIDIAN, ID 83642
(208) 846-7494 PHONE · (208) 846-7496 FAX



VEIN CENTER OF IDAHO
4519 ENTERPRISE WAY, STE. 205 · CALDWELL 83605
PHONE: 208-454-4976 · FAX: 208-454-4997



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