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:** ______________

Varicose Vein "DAILY ACTIVITY" Impact Questionnaire Form
required by insurance.

Name:______________________________ DOB:_________

Please indicate how varicose vein symptoms significantly impact specific activities of daily living. (excluding "at work" symptoms).

Please circle all that apply:

1.	*Do you have pain when taking a shower or bath?*	*Yes*	*No*
2.	*Do you have any bleeding from the veins?*	*Yes*	*No*
3.	*Does getting dressed hurt?*	*Yes*	*No*
4.	*Does it hurt if you bump them?*	*Yes*	*No*
5.	*Does it hurt to cross your legs?*	*Yes*	*No*
6.	*D you have pain with meal preparation?*	*Yes*	*No*
7.	*Do you have pain when doing household chores?*	*Yes*	*No*
8.	*Do you have pain when gardening or doing lawn work?*	*Yes*	*No*
9.	*Do you have pain with exercise?*	*Yes*	*No*
10.	*Do you have pain when grocery shopping?*	*Yes*	*No*
11.	*Do you have pain when you bend down or squat?*	*Yes*	*No*
12.	*Do you have pain when you are sleeping?*	*Yes*	*No*
13.	*Do you have pain when a pet jumps on your legs?*	*Yes*	*No*
14.	*Does it hurt to sit for an extended period of time?*	*Yes*	*No*
15.	*Doe it hurt to stand for an extended period of time?*	*Yes*	*No*

Have you been using conservative therapy with the use of medical grade compression stockings (minimum of 20mmHg) for a minimum of 3 months? *Yes* *No*

If yes, please indicate the date that you started wearing the compression stockings ___________

Please list any other pertinent symptoms of your varicose veins that have an impact on your daily living, that have not been listed above.

____

____

____

____

____

Your signature:______________________________ Date:_______________

Vein Center Of Idaho

3581 E. Overland Road
Meridian, Idaho 83642
Tel: 208-402-4467 Fax: 208-321-8626

4519 Enterprise Way Ste 205
Caldwell, Idaho 83605
Tel: 208-454-4976 Fax: 208-454-4997

Vital Signs :	B/P: ____/____	Resp: _____	Pulse:_____	Official Use Only	
HT	WT	SAO2:		G:	P:

PATIENT HISTORY

DATE:________________

Patient Name: ____ DOB:__________

Patient is here for: ____

____

Chief Complaint:

___ Pain
___ Swelling
___ Varicose Veins
___ Ulceration
___ Restless Leg Syndrome
___ Inflammation
___ Skin Rash or discoloration
___ Bleeding
___ Reddened/hard knot in vein
___ Leg Cramps
___ Spider Veins
___ Reticular Veins
___ Numbness or tingling in legs
___ Burning
___ Heaviness

Other: ____

Which Leg: ___ Right ___ Left ___ Both

How Long: ____________________

Previous Treatments: ____

____

____

Worse With:

___ Sitting
___ Standing
___ Beginning of Day
___ Walking
___ Working
___ End of Day
___ Menstrual Cycle
___ Lying Down
___ Pregnancy

Other: ____

Improved By:

___ Elevation
___ Rest
___ Beginning of Day
___ Compression Hose
___ Tylenol/Motrin Equivalent
___ End of Day
___ Fluid Pills
___ Walking

Other: ____

Social History:

Alcohol: ___ Never ___ Rare ___ Occasional/Social ___ Daily

Smoking: ___ Never ___ Quit > 10 yrs ___ Quit 1-10 yrs ___ Quit < 1 yr ___ Current Smoker

Caffeine: ___Never ___Rare ___Occasional ___Cups per Day

PATIENT HISTORY (continued)

Past Surgeries:

Coronary Artery Bypass
___ Angioplasty / Stenting
___ Peripheral Vascular Surgery

Other: ______________________________
____
____

Past Medical History:

___ Coronary Artery Disease
___ High Cholesterol
___ High Blood Pressure
___ Diabetes
___ Peripheral Vascular Disease
___ Varicose Veins

Other: ______________________________
____
____
____
____
____

Allergies:

Please List: ______________________________
____
____
____
____

Family History:

___ Coronary Artery Disease Details: ______________________________
___ High Cholesterol Details: ______________________________
___ High Blood Pressure Details: ______________________________
___ Diabetes Details: ______________________________

Other: ______________________________
____

Current Medications:

Please List: ______________________________
____
____
____
____

Patient Name: ______________________________ Date of Birth: ______________

PATIENT HISTORY (continued)

Review of Systems: Please check all that apply.

Skin:
___ Itching
___ Hives
___ Bruising
___ Bleeding

Eyes:
___ Vision changes or loss
___ Double Vision

Ears:
___ Hearing aids
___ Hearing loss
___ Pain
___ Discharge
___ Ringing
___ Infections

Nose:
___ Nosebleeds
___ Discharge
___ Infections
___ Pain

Mouth/Throat:
___ Cavities
___ Dentures
___ Bleeding Gums
___ Sores / Lesions
___ Hoarseness

Neck:
___ Goiter
___ Pain
___ Thyroid problems

Respiratory:
___ Cough
___ Blood
___ Shortness of breath
___ Asthma
___ Emphysema
___ Tuberculosis
___ Pneumonia
___ Bronchitis

Cardiovascular:
___ Chest Pain
___ Palpitations
___ Shortness of breath
___ when sleeping
___ when walking
___ Legs swelling
___ Cramps
___ Varicose veins
___ Color changes
___ Legs/feet

Gastrointestinal:
___ Vomiting
___ Constipation
___ Diarrhea
___ Heartburn
___ Blood in stool
___ Changes in stool
___ Difficulty / pain
___ in swallowing
___ Jaundice
___ Liver Disease
___ Gallbladder Disease

Genitourinary:
___ Urine frequency
___ Pain
___ Bloody urine
___ Incontinence

Hematology / Lymphatic:
___ Anemia
___ Sickle Cell
___ Hemophilia
___ Swollen Glands
___ Night Sweats
___ Itching

Neurological:
___ Headaches
___ Dizziness
___ Numbness
___ Falls
___ Tremors
___ Stroke / TIA's
___ Loss of memory
___ Problems with gait

Psychiatric:
___ Depression
___ Anxiety
___ Bipolar

Endocrine:
___ Increased thirst
___ Increased urine
___ Intolerance to heat
___ Intolerance to cold
___ Diabetes
___ Hot flashes

Allergy / Immune:
___ AIDS
___ Hepatitis B
___ Hepatitis C

Musculoskeletal:
___ Weakness
___ Paralysis
___ Stiffness
___ Joint Pain
___ Swelling
___ Arthritis
___ Gout

Patient Signature: ______________________________ Date: ____________________

NAME OF MEDICATION	DOSAGE OF MEDICATION

*PLEASE BRING LIST OF MEDICATIONS ON YOUR FIRST VISIT.
PLEASE VERIFY SPELLING OF MEDICATIONS.

Patient Name: ______________________________ Date of Birth: ______________________

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 ______________

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.

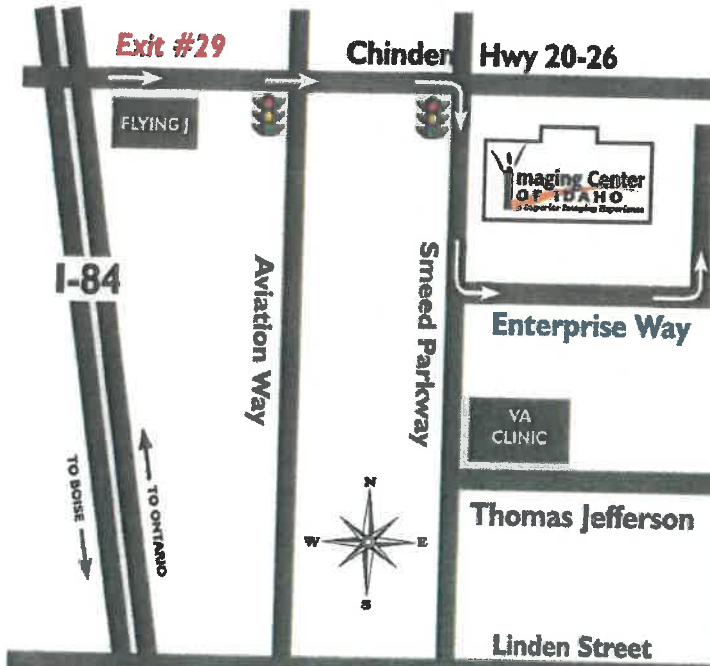
Late Cancellations: A cancellation is considered to be late when the appointment is cancelled without a **24 hour** advance notice.

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: ____________________

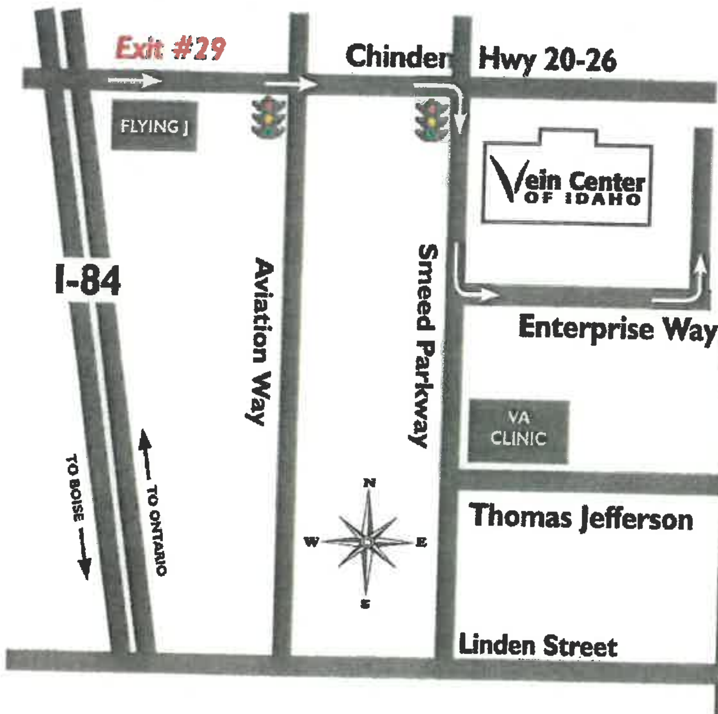
Signature: ______________________________ Date: ____________________

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



VEIN CENTER OF IDAHO
3581 E. OVERLAND RD. · MERIDIAN, ID 83642
(208) 402-4467 PHONE · (208) 321-8626 FAX