

22 Pine Street, Suite 210, **Bristol**, CT 06010 • 863 North Main Street Ext., **Wallingford**, CT 06492  
Phone: 860-229-VEIN (8346) • Fax: 860-826-1391 • [www.ctveindocs.com](http://www.ctveindocs.com)

*This form is to introduce you to our facility and to help us better serve you. We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.*

Please complete the following:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

City / State / Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email Address: \_\_\_\_\_

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How did you hear about us? : \_\_\_\_\_

Which phone # may we use to contact you? \_\_\_\_\_

Can we leave a message at this number?: \_\_\_\_\_

May we speak with your spouse / significant other / family regarding your treatment? \_\_\_\_\_

May we contact you via Email? ☐ Yes ☐ No Email address: \_\_\_\_\_

Would you like to receive our monthly promotional offers via email (you may opt out at any time)?  
☐ Yes ☐ No

Please advise any additional requests for privacy below:

\_\_\_\_\_  
\_\_\_\_\_

Print Client Name: \_\_\_\_\_

Signature of Client: \_\_\_\_\_  
(Client/ Parent or Guardian if patient is under 18) Date \_\_\_\_\_

Please print name if you are the Parent/Guardian: \_\_\_\_\_



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## Personal Profile and Medical History:

**Females:** Are you pregnant?  
☐ Yes ☐ No

Are you breastfeeding?  
☐ Yes ☐ No

## Medical History:

Please complete the following items and always inform of us any changes in your medical history and / or medications.

Medications (prescription and over the counter drugs, vitamins, herbs, and / or supplements):

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***\*ALLERGIES** to any medications?* \_\_\_\_\_

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## **Symptoms: (please check all that apply)**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Acne               | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Precocious Puberty       |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hirsutism              | <input type="checkbox"/> Psoriasis                |
| <input type="checkbox"/> Burns/skin grafts  | <input type="checkbox"/> Hormone Replacement Rx | <input type="checkbox"/> Rosacea                  |
| <input type="checkbox"/> Claustrophobia     | <input type="checkbox"/> Cold Sores             | <input type="checkbox"/> Implants                 |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Kaposi's Sarcoma         |
| <input type="checkbox"/> Shingles           | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Keloid Scars             |
| <input type="checkbox"/> Skin Cancer        | <input type="checkbox"/> Endocrine Disorders    | <input type="checkbox"/> Lupus                    |
| <input type="checkbox"/> Tattoos            | <input type="checkbox"/> Epidermolysis Bullosa  | <input type="checkbox"/> Polycystic Ovary Disease |
| <input type="checkbox"/> Thyroid Disease    | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Port-Wine Stain          |
| <input type="checkbox"/> Vitiligo           | <input type="checkbox"/> Hemorrhoids            | <input type="checkbox"/> Herpes                   |
| <input type="checkbox"/> Permanent Makeup   | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> Other: _____             |
| <input type="checkbox"/> Hepatitis          |   |   |

**Surgeries:** \_\_\_\_\_

Please list any other pertinent medical information: \_\_\_\_\_

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## **PERSONAL PROFILE & MEDICAL HISTORY – Continued:**

- |  |     |    |
|--|-----|----|
| 1. Have you used Accutane in the last 6 months?  | Yes | No |
| a. If yes, how recently? _____   |     |    |
| 2. Are you currently using glycolic acid or Retin A?   | Yes | No |
| 3. What products are you currently using on your skin?   |     |    |
| a. Describe: _____   |     |    |
| 4. Do you have any active skin diseases or infections in the area to be treated?                                 | Yes | No |
| 5. Are you allergic to latex, lidocaine, or any lotions?   | Yes | No |
| 6. Have you had any permanent cosmetic tattooing to the area to be treated?                                      | Yes | No |
| 7. Do you have any metal or other implants? Where? _____   | Yes | No |
| 8. Have you had any previous laser treatment or other skin treatments to the area to be treated? Describe: _____ | Yes | No |
| 9. Are there any moles with hair in the area to be treated?  | Yes | No |
| 10. Do you have history of skin breakouts?   | Yes | No |
| 11. Do you have any scarring as a result from your breakouts/acne?   | Yes | No |
| 12. Have you been exposed to sun with the last 4 to 6 weeks?   | Yes | No |
| a. If yes, approximate date of last exposure _____ / _____ / _____   |     |    |
| 13. Do you use tanning beds? If yes, date of last use _____ / _____ / _____                                      | Yes | No |
| 14. Do you burn easily in moderate sunlight?   | Yes | No |
| 15. Do you blush when nervous?   | Yes | No |
| 16. Do you frequently experience flakiness, tightness or dryness?  | Yes | No |
| 17. Do you use sunscreen on a regular basis?   | Yes | No |
| 18. Have you waxed, used depilatories, bleaches or other chemicals?  | Yes | No |
| 19. How much water do you normally consume daily? _____  |     |    |
| 20. Do you smoke?  | Yes | No |
| 21. Do you wear contact lenses?  | Yes | No |
| 22. Do you exercise?   | Yes | No |
| 23. Have you had microdermabrasion?  | Yes | No |
| 24. Have you had any chemical peels?   | Yes | No |
| 25. Have you had laser resurfacing?  | Yes | No |
| 26. Do you have wrinkle concerns?  | Yes | No |
| 27. Do you have scarring concerns?   | Yes | No |
| 28. Do you have sun damage concerns?   | Yes | No |
| 29. Do you have pigmentation concerns?   | Yes | No |
| 30. Do you have broken capillary concerns?   | Yes | No |



PROUD MEMBER OF

Midstate  RADIOLOGY  
ASSOCIATES LLC

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What services are you most interested in? \_\_\_\_\_

Name of family doctor: \_\_\_\_\_ Phone # \_\_\_\_\_

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**I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant has clarified any questions I did not understand.**

**Print Patient Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Parent or Guardian if patient is under 18)

**Physician's Signature:** \_\_\_\_\_

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**\*I understand that payment for any cosmetic services or products is expected in full at the time of service.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Parent or Guardian if patient is under 18)

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## Patient Photograph Release Form

### PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First MI

I hereby acknowledge that photographs may be taken of me or parts of my body before and after treatment(s). The photographs will be taken by one of the members of the Vein Centers of Connecticut medical staff. I hereby give my consent for Vein Centers of Connecticut to use the photographs under one of the following circumstances.

#### Please initial one of the following:

\_\_\_\_\_ **Internet:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Vein Centers of CT can be used on the company's website in order to inform the public about varicose vein and/or aesthetic treatment methods offered at Vein Centers of CT. Further, I release and discharge Vein Centers of CT, any employees of Vein Centers of CT, and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

\_\_\_\_\_ **All Media:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Vein Centers of CT, can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about varicose vein and/or aesthetic treatment methods offered at Vein Centers of CT. Further, I release and discharge Vein Centers of CT, any employees of Vein Centers of CT; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

\_\_\_\_\_ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care at Vein Centers of CT. I authorize Vein Centers of CT to release these photos if so requested by my insurance carrier for the purpose of determining medical necessity in order to obtain required prior authorization and/or claim reimbursement. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Vein Centers of CT.

*By signing this form, I acknowledge my consent as initialed above, and I further recognize that this form will supersede any other photo consent forms with a date prior to the date written below may be revoked at any time by written request or by completion of a new form.*

\_\_\_\_\_  
Signature (Patient or Parent/Guardian if Patient is under 18)

\_\_\_\_\_  
Date



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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES &  
CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**E-mail address:** \_\_\_\_\_

*We will not share your e-mail address or use it to transmit medical or clinical information.*

1) I have been offered a copy of the Vein Centers "Notice of Privacy Practices" posted in the office and on the website.

2) I give my permission for the **Vein Centers of Connecticut** to contact me at the following numbers and to leave a message on my answering machine or voicemail (if none, please leave blank):

MESSAGES CONCERNING APPOINTMENTS Phone ( ) \_\_\_\_\_  
Home / Mobile / Work (circle)

MESSAGES CONCERNING MEDICAL INFO Phone ( ) \_\_\_\_\_  
(For example lab or test results) Home / Mobile / Work (circle)

I give my permission for the Vein Centers of CT to communicate with the following persons regarding my health care:

**Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

*This authorization will be valid from this date until written notice of changes and/or cancellations is received in the offices of HHC Medical Group.*

3) **Assignment of Benefits:** I authorize direct payments from my primary and/or secondary insurance carrier to the **Vein Centers of Connecticut** or its designated billing agent for services rendered.

**Guarantee of Payment/Precertification By Insurer:** I will be responsible for payment of all non-covered services. If my health plan does not consider Vein Centers of Connecticut to be a participating provider or the care provided medically necessary, I will accept full financial responsibility for payment of incurred charges. The Vein Centers of CT will seek pre-authorization when required. I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify carrier of services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payment and I will be responsible for all balances.

**Consent for Treatment:** I do voluntarily consent to the rendering of such care as the provider and/or medical personnel deem necessary for my health and wellbeing. This consent shall include medical examination and diagnostic testing as well as ambulatory surgical procedures. I acknowledge that neither the provider nor the office personnel has made any guarantee or assurance as to the results that may be obtained.

4) To better provide for your care and improve your patient experience, we seek to coordinate and integrate our care delivery through our new electronic medical record (EMR). We share access to the EMR across Midstate Radiology Associates, Hartford HealthCare (HHC) and HHC affiliated practices. The current EMR does not functionally allow us to limit access to your medical record by blocking it from HHC or affiliates staff.

By signing this authorization form, you understand and agree that you are allowing disclosure of and access to all your health information, including information relating to alcohol and substance abuse/use, mental or behavioral health, and HIV/AIDS. If health information about you includes any of these types of information, you specifically authorize the release of such information to, and access to such information by, all authorized health care providers and professionals at HHC and affiliates. You may revoke this authorization at any time except to the extent it has already been relied upon. Unless earlier revoked, this consent will expire if and when the Vein Centers of Connecticut EMR no longer exists.

We no longer use a paper system for documenting patient care, and we hope that you will find the EMR system facilitates your care across Hartford HealthCare. If you don't want your medical information stored in our EMR, we unfortunately cannot care for you in this practice. If you have any questions, please do not hesitate to ask us about our EMR.

I choose to opt out of the EMR and decline to receive care at the Vein Centers of Connecticut.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent or Guardian Signature / Date** \_\_\_\_\_  
If patient is a minor (under age of 18) or has a guardian/conservator