Denver Vein Center | Aesthetic Laser Specialists | Surg One

www.denvervein.com

Dear New Patient,

Welcome to our practice! Attached are forms for you to fill out prior to your first appointment. Please be sure to bring them in with you to avoid filling them out twice. There is an Acknowledgement of Privacy Practices that you will need to sign. Copies of the Privacy Practices are available online or in the office, please let the front desk know if you would like a copy.

We will also need a copy of your Driver's License on the day of the appointment.

We look forward to meeting you! Please don't hesitate to call with any questions.

Sincerely,

Denver Vein Center Staff

401 W Hampden Place, Suite 250, Englewood, CO 80110
303-777-VEIN (8346)
303-777-8377 Fax

Denise C. Norton, M.D.
401 W. Hampden Place, Suite 250, Englewood, CO 80110
(303)777-8346

PATIENT INFORMATION

How did you hear about us?_____

Email:_____

Name (Legal): ***Last***:_____ ***First***:_____ ***M.I.***____ Nickname:_____

Address:_____ ***City***:_____ ***State***:_____ ***Zip***:_____

Sex: M / F ***Marital Status***: S / M / W / D ***Date of Birth***: _____ _____ _____
MM DD YYYY

Race: _____ ***Ethnicity:*** _____ ***Language Spoken at Home*** _____

Phone: ***Home*** ( ) _____ ***Work*** ( ) _____ ***Cell/Pager*** ( ) _____

Emergency Contact: Relative/Friend, **not living with you** (In case we are unable to contact you, or need to contact someone regarding your care in an emergency).

Contact: _____ Phone #:_____ Relationship to Patient:_____

Address: _____ City: _____State:_____ Zip:_____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES THE DAY OF SERVICE. THESE SERVICES ARE NOT COVERED BY INSURANCE.

X_____(Signed) Date:_____

(Revised 03 14 17)

Denver Vein Center | Aesthetic Laser Specialists | Surg One

Hair & Vein Removal • Sun Spot Removal • Skin Care

Name_____ Height: _____ Weight:_____
First Last

This information is necessary for your procedure. Please answer yes or no to the following questions:

YES	NO	
❑	❑	Do you take oral anti-coagulant (blood thinning) medication? _____
❑	❑	Are you pregnant or trying to become pregnant?
❑	❑	Do you use oral contraceptives?
❑	❑	Do you use hormone replacement therapy?
❑	❑	Do you smoke? (If yes, how much per day?) __ If you have smoked, when did you quit?_____
❑	❑	Do you drink alcohol? (if yes, how many drinks per day?) _____
❑	❑	Do you have any tattoos or permanent makeup?

List all prescription & non-prescription medications you are taking and doses: (use back of page if you need more room)

1._____ Dose_____ Reason_____

2._____ Dose_____ Reason_____

Do you have any allergies? Please List_____

List all Current Medical Problems

1._____

2._____

List all Surgeries and dates

1._____

2._____

Do you use any of the following Herbal Medications (check all the apply) ❑ Fish Oil ❑ St John's Wart ❑ Vitamin E

Which skin problems concern you the most (Check all that apply):

❑ Sun Damage	❑ Brown spots (Hyperpigmentation)	❑ Uneven skin tone
❑ Enlarged pores	❑ Visible exposed blood vessels	❑ Acne
❑ Upper lip lines	❑ Wrinkles	❑ Scarring
❑ Sun Spots	❑ Dry patches	❑ Unwanted Hair
❑ Clogged pores	❑ Other: _____	

What is your skin type: ❑ Dry ❑ Combination ❑ Oily ❑ Normal What skin care products are you using:_____

Have you ever had any of the following? ❑Yes (please indicate below) ❑ No
❑ Fillers ❑ Botox ❑ Implants

Do you have any of the following health problems or chronic skin disorders, past or present? ❑Yes (please indicate below) ❑ No
❑ Seizures ❑ Skin cancer ❑ Collagen (Lupus, Sarcoid, Scleroderma)

Do you have any of the following chronic skin disorders? ❑Yes (please indicate below) ❑ No
❑ Psoriasis ❑ Dermatitis ❑ Eczema ❑ Keloid Scarring ❑ Cold Sores/Fever Blisters ❑ Herpes Simplex/Blisters

Have you ever undergone any of the following treatments? ❑Yes (please indicate below) ❑ No
❑ Microdermabrasion ❑ Acid Peel ❑ Cosmetic Surgery ❑ Accutane

Are you currently removing hair by any of the following methods? ❑Yes (please indicate below) ❑ No
❑ Waxing ❑ Tweezing ❑ "Nair" type products ❑ Electrolysis ❑ Laser Hair Removal ❑ Shaving

- If so when was it done _____what area _____and what type of laser?_____

Patient Signature_____ Date:_____

SurgOne, P.C.

Protected Health Information and Communication Consent

Your physician and/or the staff may at times need to contact you and/or discuss your care with those persons whom you give us consent to do so. By completing the information below, we will be better able to serve you.

In an effort to protect your privacy and follow new federal guidelines, we have developed a policy regarding leaving medical care messages and/or discussing your care with others:

- We will ***NOT*** leave messages on voice mail or answering machines ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO***.
- We will ***NOT*** discuss your care with others ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO***.

PATIENT NAME: _____ Birth Date:_____

	May we leave a message?		May we discuss your care?	
HOME PHONE:_____	Yes	No	Yes	No
WORK PHONE:_____	Yes	No	Yes	No
CELL PHONE: _____	Yes	No	Yes	No
EMAIL*:_____			Yes	No

(*Please note that most standard email addresses (yahoo, comcast, hotmail, aol, etc)are not secure/HIPAA compliant. By writing in your email above and circling YES, you are giving us permission to contact you via unsecure email).

Please carefully consider with whom we may leave messages and/or whom you wish to have us communicate with in regards to your medical and/or billing information:

Spouse or Partner	Yes	No	If yes, name:_____
Son or Daughter	Yes	No	If yes, name:_____
Mother or Father	Yes	No	If yes, name:_____
Friend/Neighbor	Yes	No	If yes, name:_____
Other	Yes	No	If yes, name:_____

Notes:_____

Voice mail or answering machine messages may include the following information:

Specific information regarding my surgery/treatment	Yes	No
Scheduling for Lab/Test/Surgery	Yes	No
Results for Lab/Test/Surgery	Yes	No

I fully understand that this consent will remain valid until revoked in writing by me.

SIGNATURE:_____ **DATE:**_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I am in receipt of the Notice of Privacy Practices for SurgOne, P.C.

_____

Print Name

_____ _____

Signature Date

Denise Norton, MD
401 W. Hampden Place, Suite 250
Englewood, CO 80110
(303) 777-8346

Denise Norton, MD

Denver Vein Center/SurgOne, P.C. Cancellation Policy

At Denver Vein Center (a division of SurgOne, P.C.), we strive to render care in a timely and prompt manner. When a patient misses a scheduled appointment, or cancels an appointment with minimal notice, not only is that time lost, but it negatively impacts our ability to schedule other patients that require medical care. As a general rule, any patients that are more than 10 minutes late to their appointment will need to reschedule. Occasionally we will be able to accommodate the appointment, so call if you are running late. Denver Vein Center (a division of SurgOne, P.C.) has thus adopted the following Cancellation Policy. By signing below, you hereby acknowledge and agree to the following:

- Any patient that fails to show up for a scheduled appointment, or cancels a scheduled appointment with less than 48 hours' notice, will be charged a Cancellation Fee.

- Cancellation Fees can range from $25.00 up to $200.00 depending on the length of the appointment and the specialty of the provider with whom it was scheduled. SurgOne can provide the exact amount of a Cancellation Fee at the time an appointment is scheduled.

- All outstanding Cancellation Fees must be paid in full prior to the scheduling of a patient's next appointment with Denver Vein Center.

- Patients are solely responsible for the payment of Cancellation Fees, not insurance companies, Medicare, or other third-party payers.

- Any patient who, in a given 12-month period, misses three or more scheduled appointments, or cancels three or more scheduled appointments with less than 48 hours' notice, may be dismissed as a patient from Denver Vein Center.

I have read and understand the above Denver Vein Center Cancellation Policy and I agree to be bound by its terms.

_____
Patient Signature

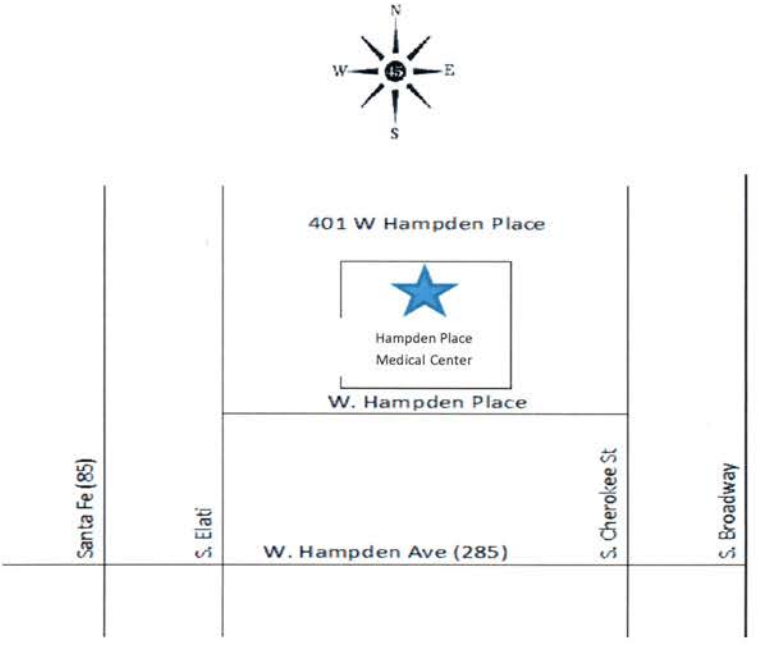
_____
Patient Name

_____
Date

401 W Hampden Place

Suite #250

Englewood, CO 80110



(303)777-8346