Denise C. Norton, M.D.
Denver Vein Center
401 W Hampden Place, Suite 250
Englewood, CO 80110
(303) 777-VEIN (8346)
Fax: (303) 777-8377
www.denvervein.com

www.denvervein.com
www.evexiasdenver.com

WELCOME TO OUR PRACTICE!

We would like to communicate some expectations to you in advance:

- Every patient will be expected to complete our Patient Information, Patient Medical History, Financial Policy, Cancellation Policy and HIPAA Privacy Practices forms. Copies of the HIPAA Privacy Practices are available online or in the office, please let the front desk know if you would like a copy.

- Current Insurance card (if applicable) and Driver's License will be copied upon check-in, for verifications reasons.

- Insurance will be billed for new consultations and ultrasounds. Co-payments are required at time of appointment. We will bill your insurance and you will be responsible for any additional co-insurance or deductible fees as determined by your insurance plan. We accept cash, check, MasterCard, Visa, Discover, American Express and Care Credit.

If you are a cash pay patient, fees will be discussed at your consultation.

Dr. Norton participates with many insurance companies; please see our website for a complete listing. If you have a question about your insurance, please call our office.

Dr. Norton runs on time. If you are going to be more than 10 minutes late for your appointment, please contact the office and we may have to reschedule you.

Your appointment is scheduled for:

Date:_____

Time:_____

Please plan to arrive 15 minutes prior to your scheduled appointment time for check in. If you cancel less than 2-businees days in advance, you will be charged a $50 Cancellation fee and we will be unable to reschedule your appointment until that is paid. Please do not hesitate to call the office if you have any questions.

Sincerely,

Denver Vein Center Staff

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

PATIENT INFORMATION

Requesting/Referring Physician_____ **Primary Care Physician**_____

Email:_____ **How did you hear about us?**_____

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

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

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

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

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

Patient's Employer: _____ **Patient's Occupation:**_____

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:_____

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

INSURANCE INFORMATION

Legible Copy of Ins. Card **Copy of Driver's License**

PRIMARY Insurance:_____
Subscriber ID#:_____ **Group#** _____
Policy Holder Name_____ **Relationship:** Self / Spouse / Child / Other_____
Policy Holder DOB: _____**Ins. Phone #:** ( )_____**Employer carrying insurance:**_____

SECONDARY Insurance:_____
Subscriber ID#:_____ **Group#:** _____
Policy Holder Name_____ **Relationship:** Self / Spouse / Child / Other_____
Policy Holder DOB:_____ **Ins. Phone #:** ( )_____ **Employer carrying insurance:**_____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES. I WILL FURNISH THIS OFFICE WITH ALL INFORMATION NECESSARY TO BILL MY INSURANCE. ANY BALANCE AFTER INSURANCE HAS PAID OR DENIED IS DUE BY ME. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE REASONABLE COST OF COLLECTION, TO INCLUDE ATTORNEY FEES. I UNDERSTAND THAT MY INSURANCE BENEFITS AND REFERRAL REQUIREMENTS ARE MY RESPONSIBILITY AND THAT ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE.

I HEREBY ASSIGN MY RIGHT AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DENVER VEIN CLINIC AND/OR EVEXIAS MEDICAL CENTER FOR THESE SERVICES AND ALL FUTURE CLAIMS AND I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

X_____(Signed) Date:_____

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Patient Name: _____ DOB: _____ Height: _____ Weight: _____ BP/P:_____

Medical History

Reason for Visit:_____ How long has it been present?_____

Vein Issues

Do you have?	Indicate	Yes
Pain	☐ Right	☐ Left
Itching	☐ Right	☐ Left
Heaviness	☐ Right	☐ Left
Aching	☐ Right	☐ Left
Spontaneous Bleeding	☐ Right	☐ Left
Thrombosis (Blood Clot/DVT)	☐ Right	☐ Left
Ulceration	☐ Right	☐ Left
Swelling/Edema	☐ Right	☐ Left
Cramping/Restless Leg	☐ Right	☐ Left
Other _____	☐ Right	☐ Left

Are you pregnant or nursing? ☐N ☐ Y
How many pregnancies have you had? _____
Are you taking hormone replacement? ☐N ☐ Y Type:_____
Are you on birth control? ☐N ☐ Y
Have you had any previous treatments for varicose veins? ☐N ☐ Y
If so, please list_____
_____
Conservative Treatments: _____
_____

SOCIAL HISTORY

Do you smoke? ☐ Current Everyday ☐ Current Some Day ☐ Never ☐ Former, when did you quit? _____
Do you use Tobacco? ☐ No ☐ Yes
Do you drink alcohol? ? ☐ No ☐ Yes (If yes, how many drinks per day?) _____

FAMILY HISTORY

Do you have a history of Varicose Veins in your family?	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Grandparent
Do you have a history of Hypertension in your family?	☐ Father ☐ Mother ☐ Brother ☐ Sister
Do you have a history of Cancer in your family? Type:_____	☐ Father ☐ Mother ☐ Brother ☐ Sister
Do you have History of Bleeding Problems in your family?	☐ Father ☐ Mother ☐ Brother ☐ Sister
Do you have a history of Heart Attack in your family?	☐ Father ☐ Mother ☐ Brother ☐ Sister
Do you have a history of Diabetes in your family?	☐ Father ☐ Mother ☐ Brother ☐ Sister
Do you have a history of Hyperlipidemia in your family?	☐ Father ☐ Mother ☐ Brother ☐ Sister
Do you have a history of Asthma in your family?	☐ Father ☐ Mother ☐ Brother ☐ Sister

List all Current Medical Problems

1. _____
2. _____
3. _____

List all Surgeries and dates

1. _____
2. _____
3. _____

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_____
3. _____ Dose_____ Reason_____

Allergies Are you allergic to any medicines, tape, Latex etc? _____
_____
_____

Patient Signature_____ Date:_____

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YOUR MEDICAL HISTORY / REVIEW OF SYSTEMS

Do you have any of the following problems? Please provide details.

CONSTITUTIONAL

Fever	☐ No	☐ Yes	_____
Chills	☐ No	☐ Yes	_____
Weight loss	☐ No	☐ Yes	_____

CANCER

Have you ever been diagnosed with cancer? ☐ No ☐ Yes

Type: _____
Treatment: _____
Location: _____

COMMUNICABLE DISEASES

AIDS / HIV	☐ No	☐ Yes	_____
Hepatitis A / B / C	☐ No	☐ Yes	_____
STD	☐ No	☐ Yes	_____
Tuberculosis/Malaria	☐ No	☐ Yes	_____

HEAD, EYES, EARS, NOSE, THROAT

Ear	☐ No	☐ Yes	_____
Eye	☐ No	☐ Yes	_____
Nose/Sinus	☐ No	☐ Yes	_____
Throat	☐ No	☐ Yes	_____

RESPIRATORY

Shortness of breath	☐ No	☐ Yes	_____
Chronic cough	☐ No	☐ Yes	_____
Emphysema/COPD	☐ No	☐ Yes	_____
Asthma	☐ No	☐ Yes	_____
Bronchitis	☐ No	☐ Yes	_____
Pneumonia	☐ No	☐ Yes	_____
Pulmonary embolism	☐ No	☐ Yes	_____
Sleep Apnea	☐ No	☐ Yes	_____

CARDIOVASCULAR

Heart murmur	☐ No	☐ Yes	_____
Chest pain	☐ No	☐ Yes	_____
Palpations/heart racing	☐ No	☐ Yes	_____
Congestive heart failure	☐ No	☐ Yes	_____
Heart attack	☐ No	☐ Yes	_____
High blood pressure	☐ No	☐ Yes	_____
Pacemaker	☐ No	☐ Yes	_____
Artificial Heart Valve	☐ No	☐ Yes	_____
Cardiac Stent/Angioplasty	☐ No	☐ Yes	_____

GASTROINTESTINAL

Abdominal pain	☐ No	☐ Yes	_____
Nausea / Vomiting	☐ No	☐ Yes	_____
Constipation/Diarrhea	☐ No	☐ Yes	_____
Colitis	☐ No	☐ Yes	_____
Diverticulitis	☐ No	☐ Yes	_____
Hiatal Hernia	☐ No	☐ Yes	_____
Reflux Esophagitis	☐ No	☐ Yes	_____
Irritable bowel	☐ No	☐ Yes	_____
Ulcers	☐ No	☐ Yes	_____
Pancreatitis	☐ No	☐ Yes	_____
Cirrhosis/Jaundice	☐ No	☐ Yes	_____
Gallstones	☐ No	☐ Yes	_____
Hemorrhoids	☐ No	☐ Yes	_____

GENITOURINARY / GYN

Prostate	☐ No	☐ Yes	_____
Uterine	☐ No	☐ Yes	_____
Ovarian	☐ No	☐ Yes	_____
Bladder infections	☐ No	☐ Yes	_____
Kidney	☐ No	☐ Yes	_____

MUSCULOSKELETAL / SKIN

Back/Neck/Joint issues	☐ No	☐ Yes	_____
Rash/Skin breakdown	☐ No	☐ Yes	_____
Arthritis (type)	☐ No	☐ Yes	_____
Fractures	☐ No	☐ Yes	_____
Osteoporosis	☐ No	☐ Yes	_____

NEUROLOGICAL

Numbness/tingling	☐ No	☐ Yes	_____
Loss of strength	☐ No	☐ Yes	_____
Stroke (CVA/TIA)	☐ No	☐ Yes	_____
Headaches (type)	☐ No	☐ Yes	_____
MS	☐ No	☐ Yes	_____

ENDOCRINE

Excessive thirst	☐ No	☐ Yes	_____
Diabetes	☐ No	☐ Yes	_____
Thyroid	☐ No	☐ Yes	_____
Parathyroid	☐ No	☐ Yes	_____

HEMATOLOGIC

Swollen lymph glands	☐ No	☐ Yes	_____
Anemia	☐ No	☐ Yes	_____
Lupus	☐ No	☐ Yes	_____

PSYCHIATRIC (MENTAL STATUS/EMOTIONAL)

Nervousness	☐ No	☐ Yes	_____
Depression	☐ No	☐ Yes	_____
Other (describe)	☐ No	☐ Yes	_____

HORMONAL (WOMEN)

Hot Flashes	☐ No	☐ Yes	_____
Night Sweats	☐ No	☐ Yes	_____
Vaginal Dryness	☐ No	☐ Yes	_____

HORMONAL (MEN & WOMEN)

Sleep Problems	☐ No	☐ Yes	_____
Sexual Problems/Low Libido	☐ No	☐ Yes	_____
Difficulty Losing Weight	☐ No	☐ Yes	_____
Feeling Cold	☐ No	☐ Yes	_____
Physical/Mental Exhaustion	☐ No	☐ Yes	_____
Decline in overall well-being	☐ No	☐ Yes	_____
Decrease in muscular strength	☐ No	☐ Yes	_____

Patient Signature:_____ Date:_____