Rose City

Vein Center

PATIENT INFORMATION

	Date	Time
Free Screen	_____	_____
Ultra-sound	_____	_____
Stocking check	_____	_____

_____
Source: TV, Radio, Web, Friend, or Referral

Name _____ _____ _____
Last First Middle

DOB _____ Age _____ Sex: **M** **F**

Phone _____ (cell/home/other) Phone _____ (cell/home/other)

Address _____ _____ _____ _____
City State Zip

Email _____

Employer _____ Occupation _____

Emergency Contact _____ _____ _____
Name Relation Phone

Primary Care Physician: _____ Phone: _____

Clinic: _____ Fax: _____

Address: _____

Referring Physician: _____ Phone: _____

Clinic: _____ Fax: _____

Address: _____

Participant Consent

I understand that I will be screened for signs of venous disease. I further understand that this screening does not constitute a complete medical examination or diagnosis. I have read and understand this consent form.

Receipt of Privacy Practices; HIPPA acknowledgement

I have received a copy of the Notice of Privacy Practices for Rose City Vein Center. Rose City Vein Center reserves the right to modify the privacy practices outlined in the notice.

_____ _____

Signature (Patient or Patient Representative) Date