

**SUPERIOR IMAGING SPECIALISTS  
PATIENT INFORMATION**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

SEX: Male Female      MARITAL STATUS: Married Single Widowed Divorced Separated

Address \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**RESPONSIBLE PARTY**  
(If other than self)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone: \_\_\_\_\_

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**INSURANCE INFORMATION**  
**(Office staff will photocopy your insurance cards)**

**1<sup>st</sup> Insurance:** \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**2<sup>nd</sup> Insurance:** \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**INSURANCE AUTHORIZATION/MEDICARE OR MEDICAID AUTHORIZATION**

I authorize Superior Imaging Specialists to furnish information to insurance carriers concerning this illness and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I CERTIFY that information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct and request that said payment of authorized benefits be made on my behalf. This assignment will continue as long as I remain eligible for such benefits. I understand I am responsible for any benefit co-pays or deductibles not covered by these plans.

X \_\_\_\_\_  
Signature of patient or authorized representative      Date

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

The notice of Privacy Practices for Marquette General Health System has been made available to me for my review. I understand that I may request a copy of the notice or obtain a copy from their website at [www.mgh.org](http://www.mgh.org) at any time.

X \_\_\_\_\_  
Patient/Representative Signature      Date

**A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL**



## PATIENT ADMISSION CONSENT

Knowing that I have a condition requiring clinic and medical treatment, I do hereby voluntarily consent to such routine and/or diagnostic procedures and clinic care by The Vein Clinic of Northern Michigan as deemed necessary by my physician (or his designees) or by staff of the clinic, and do hereby voluntarily consent to such medical treatment by my physician or physicians (or by their designees) as is deemed necessary.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of said clinic care and medical treatment which I have authorized.

I authorize you to release to my insurance company or to the agency assuming responsibility for cost of health care any and all information, which you possess relative to my condition and treated for at The Vein Clinic of Northern Michigan.

It is understood that the clinic is housed in a hospital, which is a teaching institute and that unless the hospital is notified to the contrary in writing, the patient may participate as a teaching subject in the medical nursing programs of the institution.

“I hereby authorize the Vein Clinic of Northern Michigan that, upon inquiry as to my general condition, it may release at its discretion my name, address, age, sex, reason for admission, and general nature of condition. I understand that I have the right to request that the Vein Clinic of Northern Michigan does not disclose this information in whole or in part.”

### **Agreement of Payment**

In consideration of these services rendered, the undersigned does hereby expressly agree to pay and guarantee in full any and all charges for clinic services rendered for the patient by the Vein Clinic of Northern Michigan, Marquette, Michigan.

This form has been fully explained to me and I certify that I understand its contents:

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Provided by Superior Imaging Specialists, PC (FEIN: 38-3628237)**

**906-225-7808 or 1-800-562-9753 x7808**

**THEVEINCLINIC.ORG**



## Patient Questionnaire & Medical History

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ GENDER:  Male  Female

DATE OF BIRTH: \_\_\_\_\_ MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  WIDOWED

EMPLOYMENT:  WORKING  UNEMPLOYED  RETIRED OCCUPATION: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ CITY: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ CITY: \_\_\_\_\_

HOME PH.: \_\_\_\_\_ WORK PH.: \_\_\_\_\_ CELL PH.: \_\_\_\_\_

HOW DID YOU HEAR ABOUT THE VEIN CLINIC? (SELECT ALL THAT APPLY)

FRIEND/FAMILY MEMBER  WEBSITE/INTERNET  REFERRING PHYSICIAN  NEWSPAPER AD  
 TELEVISION  YELLOW PAGES  OTHER: \_\_\_\_\_

### VENOUS QUESTIONS/MEDICAL HISTORY:

1. Please check all symptoms you are currently experiencing related to your leg/veins, which are the reason you are here today:

ACHE  HEAVY SENSATION  PAIN/BURNING SENSATION  
 SWELLING  NIGHT CRAMPING  REDNESS/INFLAMED  
 BULGING VEIN  DARKENED SKIN  SCALY SKIN  
 OTHER: \_\_\_\_\_

2. How long have you had the above symptoms? \_\_\_\_\_

3. Does prolonged sitting or standing aggravate your symptoms? YES NO

4. Are your symptoms getting worse? YES NO

5. Has anyone in your family had a history of varicose veins? YES NO

A. If yes, who? \_\_\_\_\_

6. Have you ever had treatment for your veins? YES NO

A. If yes, when, by who, and what type of treatment?  
\_\_\_\_\_  
\_\_\_\_\_

7. Do you currently or have you ever worn compression hose? YES NO

A. If yes how long did you wear them? \_\_\_\_\_

B. Do you find the usage of compression hose effective in relieving symptoms? YES NO

8. Have you ever been treated for a blood clot in your legs? YES NO

A. If yes, when and which leg? \_\_\_\_\_

9. **GYNECOLOGICAL HISTORY (Female Patients Only):**

- A. Do you have children? YES NO
- B. If yes, how many and what are their ages: \_\_\_\_\_
- C. If yes, did your veins develop or worsen with pregnancy? YES NO

**PAST SURGICAL HISTORY:**

Please list all surgeries you have had.

SURGERY	YEAR SURGERY PERFORMED

**FAMILY HISTORY**

Family background may be related to medical conditions. Please fill in the following chart to the best of your ability. Please include your mother, father, siblings and children.

FAMILY MEMBER	DECEASED (Y/N)	CURRENT AGE OR AGE AT DEATH	CAUSE OF DEATH	ILLNESSES
Example: Mother	No	72	Not Applicable	Diabetes

**GENERAL MEDICAL HISTORY:**

10. Do you have an allergy to LATEX? YES NO
11. Please list any allergies you have: \_\_\_\_\_
12. Do you smoke? YES NO
- A. If, yes, how long have you smoked? \_\_\_\_\_
- B. If you did smoke, but quit, how long has it been since you quit? \_\_\_\_\_
13. Please select the following medical conditions you currently have:
- HEART DISEASE     LIVER DISEASE     LUNG DISEASE
- CANCER     DIABETES     OTHER: \_\_\_\_\_

14. Please list current medications:

- |          |           |
|----------|-----------|
| 1. _____ | 7. _____  |
| 2. _____ | 8. _____  |
| 3. _____ | 9. _____  |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

**REVIEW OF SYMPTOMS:**

Indicate the symptoms that apply to you at this time.

**GENERAL**

- |                                 |   |                                    |                                  |
|---------------------------------|---|------------------------------------|----------------------------------|
| <input type="checkbox"/> Fever  | <input type="checkbox"/> Weight Loss        | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Change in appetite |                                    |                                  |

**HEAD/EARS/EYES/NOSE/THROAT**

- |   |   |                                   |   |
|---|---|-----------------------------------|---|
| <input type="checkbox"/> Headache         | <input type="checkbox"/> Sore Throat    | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Swollen Glands |                                   |   |

**RESPIRATORY/LUNGS**

- |  |   |   |                                   |
|--|---|---|-----------------------------------|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Productive Cough | <input type="checkbox"/> Wheezing |
|--|---|---|-----------------------------------|

**CARDIOVASCULAR**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Chest Pressure      | <input type="checkbox"/> Palpitations          | <input type="checkbox"/> Fast Heart Rate     | <input type="checkbox"/> Slow Heart Rate    |
| <input type="checkbox"/> Ankle/Foot Swelling | <input type="checkbox"/> Ulcers on Feet/Legs   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Varicose Veins      | <input type="checkbox"/> Leg Pain When Walking |  |   |

**GASTROINTESTINAL/DIGESTIVE**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Nausea          | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Abdominal Pain      | <input type="checkbox"/> Abdominal Mass |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Can't Control Stool | <input type="checkbox"/> Bloody Stool   |
| <input type="checkbox"/> Vomiting        | <input type="checkbox"/> Difficulty Swallowing |  |   |

**URINARY**

- |  |   |                                    |                                       |
|--|---|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Frequency | <input type="checkbox"/> Incontinence |
|--|---|------------------------------------|---------------------------------------|

**MUSCULOSKELETAL**

- |  |                                      |   |   |
|--|--------------------------------------|---|---|
| <input type="checkbox"/> Muscle Loss           | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Joint Pain         | <input type="checkbox"/> Joint Swelling |
| <input type="checkbox"/> Loss of Limb Movement | <input type="checkbox"/> Back Pain   | <input type="checkbox"/> Difficulty Walking |   |

**SKIN**

- |                                 |                                   |                                      |
|---------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Bruising | <input type="checkbox"/> Skin Ulcers |
|---------------------------------|-----------------------------------|--------------------------------------|

**NEUROLOGICAL**

- |                                   |                                   |                                   |
|-----------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
|-----------------------------------|-----------------------------------|-----------------------------------|