Midwest Vein Treatment Clinic, Inc

Sukir Sinnathamby, M.D.
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900 S. DIXIE DRIVE, SUITE 50, VANDALIA, OH 45377
937-281-0200 • Fax 937-281-0203

You have been scheduled on _____ Please arrive at _____

PLEASE COMPLETE AND BRING THIS INFORMATION

NAME_____
LAST FIRST M

Address _____

City _____State_____ ZIP_____

Phone _____Home____ Cell_____

Age _____ Date of Birth _____

Email Address _____

Social Security #_____

Occupation _____

Work Phone _____
Marital Status ____M ____D____ S ____ W ____
Spouses Name _____

Family Doctor _____
Address _____
_____
Phone_____

Referring Doctor _____
Address _____
Phone _____

Preferred Pharmacy _____
Pharmacy Phone _____

HEALTH INSURANCE
Primary Carrier _____

Insurance Address _____

Insurance ID#_____

Group #_____

Policy holder's name, date of birth and social security number **(required for insurance)**
_____
_____

Secondary Carrier

_____

Insurance Address
_____

Group Number _____
Policy holder's name, date of birth and social security number **(required for insurance)**
_____
_____

EMERGENCY CONTACT_____
Relationship _____
Phone _____

Your first visit is a consultation with the provider. If you have any questions regarding the information enclosed, please call our office. Any applicable co-pays will be collected at the time of each visit.

PLEASE BRING YOUR INSURANCE CARD AND PHOTO ID WITH YOU

NAME_____

MEDICAL HISTORY

Male _____ Female _____ Age _____ Height _____ Weight _____

What problem are you seeking care for?

_____

_____

Check and or list all illnesses/problems you have been treated for in the past and present:

____ none	____ heart attack	____ anxiety	____ HIV/AIDS
____ bleeding disorder	____ angina	____ depression	____ hepatitis
____ blood clots/DVT	____ CHF	____ high blood pressure	____ tuberculosis
____ asthma	____ heart murmur	____ low blood pressure	____ stroke
____ COPD	____ arthritis	____ diabetes	____ seizures
____ cancer/type	____ neuropathy	____ Raynaud's	____ other illnesses
_____			_____

Have you had Covid or a Covid vaccine in the last 90 days? Yes/When _____ No _____

Please list any surgeries you have had and the dates:

_____

_____

_____

_____

Any planned surgeries scheduled? _____

DRUG ALLERGIES: _____ **None:** _____

Do you have a LATEX ALLERGY? Yes _____ No _____

Are you taking a blood thinner? Yes _____ Reason _____ No _____

MEDICATION, DOSE AND FREQUENCY

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Have you ever smoked tobacco? Yes _____ No _____ Are you currently smoking? Yes _____ No _____

NAME _____

Venous History

Past Medical History:

1. Have you ever had vein procedures? Yes ___ No ___ Type of procedures/Dates_____

_____

2. Have you ever had vein injections? Yes ___ No ___ Cosmetic or non-cosmetic/Dates_____
3. Have you ever had a blood clot? Yes ___ No ___ When/Location _____
4. Have you ever had a pulmonary embolism? Yes ___ No ___ When _____
5. Have you ever had phlebitis? Yes ___ No ___ When/Location _____
6. Have you ever had bleeding varicose veins? Yes ___ No ___ When/Location _____
7. Have you ever had migraines? Yes ___ No ___ When/How often _____

Family History: (M) mother (F) father (S) sister (B) brother (CM) child male (CF) child female

Varicose veins ____ Spider veins ____ Deep vein clot ____ Stroke ____ Blood clotting disorder ____

Pulmonary Embolism ____

Current Vein History: Do you experience any of the following symptoms in your legs?

Pain/aching	Right ____	Left ____
Heaviness	Right ____	Left ____
Tiredness/fatigue	Right ____	Left ____
Cramping	Right ____	Left ____
Itching/burning	Right ____	Left ____
Swelling/edema	Right ____	Left ____
Restless legs	Right ____	Left ____
Skin discoloration	Right ____	Left ____
Bleeding	Right ____	Left ____
Sores/Ulcers	Right ____	Left ____
Slow healing wounds	Right ____	Left ____
Which leg bothers you the most	Right ____	Left ____

Have you taken any pain medication for relief of symptoms in your legs?

Aspirin ____ Ibuprofen ____ Aleve ___ Tylenol ___ Other _____

Do you elevate your legs to relieve your leg symptoms? Yes ____ No ____

Do your vein/leg symptoms interfere in your daily activities? Yes ____No ____

Have you ever worn compression stockings? Yes ___ **For how long?** _____ No ____

Have you done any of the following to help with your symptoms? Exercise _____ Weight loss _____

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8101A Miller Farm Lane Centerville, OH 45458
900 S. Dixie Dr. Suite 50 Vandalia, OH 45377

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are qualified to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Vein Surgery Patients: As a courtesy, we will send your photos and medical information to your insurance company. The letter will request that your insurance company send you a letter stating whether these procedures/supplies are covered and how much they will pay. This letter is normally sent out within 1 week of your first visit to our office. If you do not hear from your insurance company within 4-6 weeks, we recommend that you contact them for their response. We have no control over whether they respond to this request. (This letter will not be sent to Medicare or secondary insurance since they do not require it).

Payment for services not covered by insurance is due at the time services are rendered unless payment arrangements have been approved in advance by our management. All other balances must be paid within 90 days of the date of service. Returned checks and balances older than 90 days will be subject to additional collection fee of $25 and interest charges of 1 ½% per month.

We require at least two (2) weeks notice for all vein surgery cancellations. A $200.00 fee will be charged if a two (2) week notice is not given.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract.
2. Our fees are considered to fall within the acceptable range by most insurance companies. This statement does not apply to insurance companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Midwest Vein and Laser and doctors participate ONLY with the insurance companies listed on our current information sheet.
5. For Medicare Risk Plan HMO patients, we do not participate with your HMO, therefore you will be responsible for all charges out of pocket.
6. For Medicare patients, we do accept assignment with Medicare. Therefore, we will file your vein surgery claims to Medicare and you will be responsible for the Medicare co-insurance amount and deductible. You will be responsible for payment of any non-covered, cosmetic services/supplies and no claim will be sent to Medicare.
7. **Any insurance payment paid to you by your insurance company must be paid to Midwest Vein and Laser, Inc. within one (1) week of receipt**. **If payment is not received in full, this money will incur a monthly 1.5% interest charge.**

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I request that payment of authorized Medicare/Insurance benefits are made to Midwest Vein Treatment Clinic, Inc. for any services furnished to me by that physician. I authorize release to the Health Care Financing Administration or said insurance company and its agents any medical information about me needed to determine these benefits or benefits payable for related services.

I have read and fully understand the above statements regarding payment policies and agree that I am responsible for any fees incurred on account of services provided to me.

_____ _____

Patient/Guarantors Signature Date

_____ _____

Witness Date