RANDALL
VEIN & LEG

Welcome to Randall Pain Management! Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call 405-438-0913 if you have any questions or are unsure how to complete any section of this form.

I. PATIENT INFORMATION:

Name:_____ Date of Birth:_____Sex:_____
Language:_____ Race:_____ Ethnicity: _____
Height:_____ Weight:_____
Home Address:_____
City:_____ State:_____ Zip:_____ Marital Status:_____
Home Phone #:_____ SS #:_____
Cell Phone #:_____ Work#:_____
Voice Mail: Y - N Best Contact: Home / Work / Cell / Email Email:_____
Emergency Contact:_____Relationship:_____Phone#_____
Employer:_____
Referring Physician: _____ Primary Care Doctor: _____
Pharmacy: _____ Pharmacy Phone: (_____) _____-_____ II.

INSURANCE INFORMATION:

Primary Insurance	Secondary Insurance
Insurance Co.:_____	Insurance Co.:_____
Policy#:_____	Policy#:_____
Group #:_____	Group #:_____
Name of Guarantor:_____	Name of Guarantor:_____
Insured's Date of Birth:_____	Insured's Date of Birth:_____
Insured's ID or SS:_____	Insured's ID or SS:_____
Employer(if group policy)_____	Employer(if group policy)_____

III. PAYMENT OF BENEFITS

I direct payment to Dr. Steve E. Randall of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, but not to exceed the reasonable and customary charges for those services.

_____ _____
Signed (Insured Person) Date

IV. RELEASE OF INFORMATION

I hereby authorize Randall Pain Managment to release any information acquired in the course of my examination or treatment.

_____ _____
Signed (Patient) Date

By providing an email you agree to receive updates, news, and general information from Randall Pain Management. We respect your right to privacy and will not share your information.

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NEW PATIENT INFORMATION

Name: _____ Date of Birth: _____

Please answer the following questions about your symptoms as accurately as possible.

LOCATION: Where is your pain located? ___ Right Leg ___ Left Leg ___ Both Legs

QUALITY: How would you describe the pain?
___ Aching ___ Burning ___ Stabbing
___ Throbbing ___ Sharp ___ Dull
___ Occasional ___ Frequent ___ Constant

SYMPTOMS: ___ Worse during the day ___ Worse at night
___ Legs swell equally ___ Legs do not swell equally
(More in ___Right or ___Left)

SEVERITY: ___No pain ___Mild ___Moderate ___Severe ___Intermittent ___Constant

PAIN LEVEL: Today: ___/10 Worst Pain: ___/10

DURATION: How long have you had leg symptoms or varicose veins? _____

ONSET: Did the symptoms start ___ Suddenly or ___ Gradually?

TIMING: How often do you experience symptoms?
___Every day ___ 2-3 days per week ___4-6 days per week

HISTORY OF SYMPTOMS: ___ began after injury ___ began after clot ___ began after pregnancy
___ family history of blood clot ___ family history of varicose veins

ASSOCIATED SYMPTOMS: ___ Numbness ___ Tingling ___ Redness
___ Discoloration ___ Rash ___ Itching
___ Warmth ___ Heaviness ___ Bleeding from vein
___ Ulcer (date of onset: _____) ___ Recurrent Ulcers

ALLEVIATING FACTORS: ___ Walking ___ Elevation ___ Sitting
___ Lying down ___ Rest ___ Medication
___ Compression Socks

AGGRAVATING FACTORS: ___ Walking ___ Sitting ___ Stairs
___ Lying down ___ Standing for extended periods

Have you tried compression stockings? ___ Yes ___ No
If yes, for how long? _____

Do compression stockings improve your symptoms? ___ Yes ___ No

Have you had previous vein treatment? ___ Vein Stripping ___ Vein Injections ___ Vein Laser
Dates of treatment: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PAST MEDICAL HISTORY

Please list your past medical conditions:

___ High blood pressure (requiring medication)
___ High cholesterol (requiring medication)
___ Peripheral Artery Disease
___ Stents
___ Skin ulcer
___ Allergic reaction to Latex
___ Allergic reaction to anesthesia
___ Other bleeding disorder
___ Other medical problems _____
_____
_____

___ Hemophilia
___ Factor 5 Leiden
___ Neuropathy
___ HIV/AIDS
___ Hepatitis
___ Deep Vein Thrombosis
___ Other heart problems

Please list any surgeries you have had:

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

Are you allergic to any medications? NKDA □

_____
_____

Please list all of the medications you currently take:

Medicine	Dose	How many times daily?

Do you take any of the following?

Aspirin	____ No	____ Yes
Plavix	____ No	____ Yes
Warfarin (Coumadin)	____ No	____ Yes
Other blood thinner	____ No	____ Yes

What is your height? _____ Weight? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SOCIAL HISTORY

Is there a history in your family of spider or varicose veins? If yes, who? _____
_____
_____

Is there a history in your family of small or deep vein thrombosis, stroke, or clotting disorders?
If yes, who? _____
_____
_____

Do you currently smoke? ____ No ____ Yes
If yes, how many packs per day? _____
For how many years? _____

If you don't currently smoke, did you smoke in the past? ____ No ____ Yes
If yes, how long ago did you quit? _____
Before you quit, how many packs per day did you smoke? _____
Before you quit, how many years did you smoke? _____

Do you currently drink alcohol? ____ No ____ Yes
If yes, how many drinks per week? _____

Are you currently ____ Married ____ Single ____ Divorced
How many children do you have? _____

Do you currently work? ____ No ____ Yes, where? _____
What do you do? _____
For how long? _____

How did you hear about us? _____

I understand that for my doctor to provide me with the best possible care, I must provide complete and accurate information about my medical history. I certify the information I have provided is true and correct.

_____ ____/____/____
Patient Signature Date

Review of Systems

(Circle all that apply)

Constitutional: Fever, Chills, Night sweats

Eyes: Pain, Vision change

ENMT: Difficulty hearing, Ear pain, Vertigo, Tinnitus, Nose/Sinus problems, Oral abnormalities

Cardiovascular: Chest pain on exertion, Shortness of breath when walking, Shortness of breath when lying down, Palpitations, Known heart murmur

Respiratory: Cough, Wheezing, Shortness of breath, Bronchospasm

Gastrointestinal: Nausea, Vomiting, Frequent diarrhea, Constipation

Musculoskeletal: Leg muscle aches, Leg pain, Leg heaviness, Leg cramps, Ankle pain, Knee pain, Hip pain, Back pain

Skin in the legs: Dryness, Spider veins, Darkening, Rash, Ulcers, Redness

Neurologic: Leg weakness, Leg numbness, Leg tingling, Restless legs

Psychiatric: Depression, Anxiety, Panic attacks, Sleep disturbances

Endocrine: Fatigue, Cold intolerance, Heat intolerance, Hair loss on legs

Hematologic: Varicose veins in legs/feet, Swelling in legs/feet, Bleeding from varicose vein, Vein inflammation

Allergic: Itching in legs/feet, Hives

I_____ agree that in return for the services provided by Steve Randall, MD, PLLC I will pay my/the account at the time service is rendered or will make financial arrangements satisfactory to Steve Randall, MD, PLLC. If co-payments and/or deductibles are designated by my insurance company or health plan I agree to pay them to Steve Randall, MD, PLLC. All co-payments and past due amounts are to be paid at the time of service. I understand and agree that if my account is delinquent, I may be turned over to a collection agency.

NON-COVERED SERVICES

I understand that Steve Randall, MD, PLLC contracts with health care service plan(s) (i.e. HMO, PPO, etc.) that relate only to items and services which are "covered" by health care service plans. Accordingly, the undersigned accepts full personal responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include but are not limited to services not specified as being covered in the patient's contract with a health care service plan, or in the benefit summary the health care plan furnished to the patient.

HMO REFERRALS

If your insurance has designated a primary care physician (PCP) it is your responsibility and/or your PCP to provide an authorization to see a specialist. Therefore it is understood by you, the patient, that a prior authorization from your PCP for an office visit is required. If the authorization is not provided, whether by yourself or through your insurance carrier or your PCP, you will be asked to either reschedule your appointment or pay for the full visit at the time of service and you file to your insurance carrier.

SELF-PAY ACCOUNTS

Self-pay accounts are patients who are covered by carriers that the practice does not participate in or patients without an insurance plan at the time of service. The undersigned agrees that they are individually obligated to pay the full charges at the time of service. The undersigned agrees that they are individually obligated to pay the full charges at the time of service based on current charge schedule in effect.

NON-PARTICIPATING INSURANCE ACCOUNTS

The financial obligations of patients who are insured by carriers with which the practice does not participate are considered "out-of-network" plans and will be required to pay the co-pay and/or visit in full at the time of service.

IF YOU REQUIRE A PROCEDURE/SURGERY

If you require a procedure/surgery your physician/pre-cert staff will work with you to select a date that will accommodate your schedule. Also, one of our staff will review any anticipated financial responsibilities you will have. You may be asked to make a pre-payment to cover the amount of your deductible/percentage for surgical care and this payment will be due before the procedure/surgery is performed. Please feel free to talk to our staff about payment plans if you have a special financial situation. Allow our office to work with you to ensure you are able to be provided quality care.

RETURNED CHECKS

All returned checks will be assessed a $35.00 fee.

COPAYS & DEDUCTIBLES

All copays & deductibles are due at time of service. Your insurance requires you to pay your portion due, which is on your insurance card. If you cannot pay at the time of service you will be re-scheduled.

PATIENT PAYMENT PLANS

Steve Randall, MD, PLLC has the ability to provide a payment agreement to any patient that is unable to pay their bill/balance in full. Please ask to speak with our Practice Manager to provide you with the terms and payment arrangements you may qualify to receive.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____ _____

Driver's License # of Responsible Party State SS# of Responsible Party

CONSENT TO TREAT

I consent to necessary medical treatment as recommended by my physician. I understand that I am personally responsible for payment for anything that insurance may not cover including all recommended medical services, such as preventative health exams, immunizations screening test, detailed phone consultations, copies of medical records, preparation of reports, forms and summaries.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical records information, and insurance authorization. These authorizations shall remain until written notice is given by me revoking said authorization.

Patient Signature: _____ Date: _____

PRIVACY NOTIFICATION

As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by the physician, office staff, and others outside of this office who are involved in my care and treatment for the purpose of providing health care services.

I acknowledge that I have been provided an opportunity to review the Notice of Privacy and Practices which explains how my medical information will be used and disclosed.

Patient Signature: _____ Date: _____

CONSENT TO CORRESPONDENCE

Consent to receive health notifications, appointment correspondence, announcements, and billing via email and portal access.

Patient Signature: _____ Date: _____

Steve E. Randall, MD

Dear Patient:

Our office has a fee for **No Show** and **No Call Appointments.** We require a 24-hour notice to our office to cancel or reschedule your appointment. A $50.00 fee will be required and needs to be paid in cash on your next office visit. This will be a separate payment from your normal office co-pay or coinsurance payment.

The purpose of this fee is to encourage our patients to be responsible and appreciate that this time is reserved for you and it is your responsibility to call and cancel or reschedule your appointment. We always have patients that need to come in for urgent visits and we need to keep available appointments open for these patients.

We understand that we all have emergency situations, and these will be considered based on the situation and a decision regarding the fee will be made by our office.

Thank you for your understanding and cooperation.

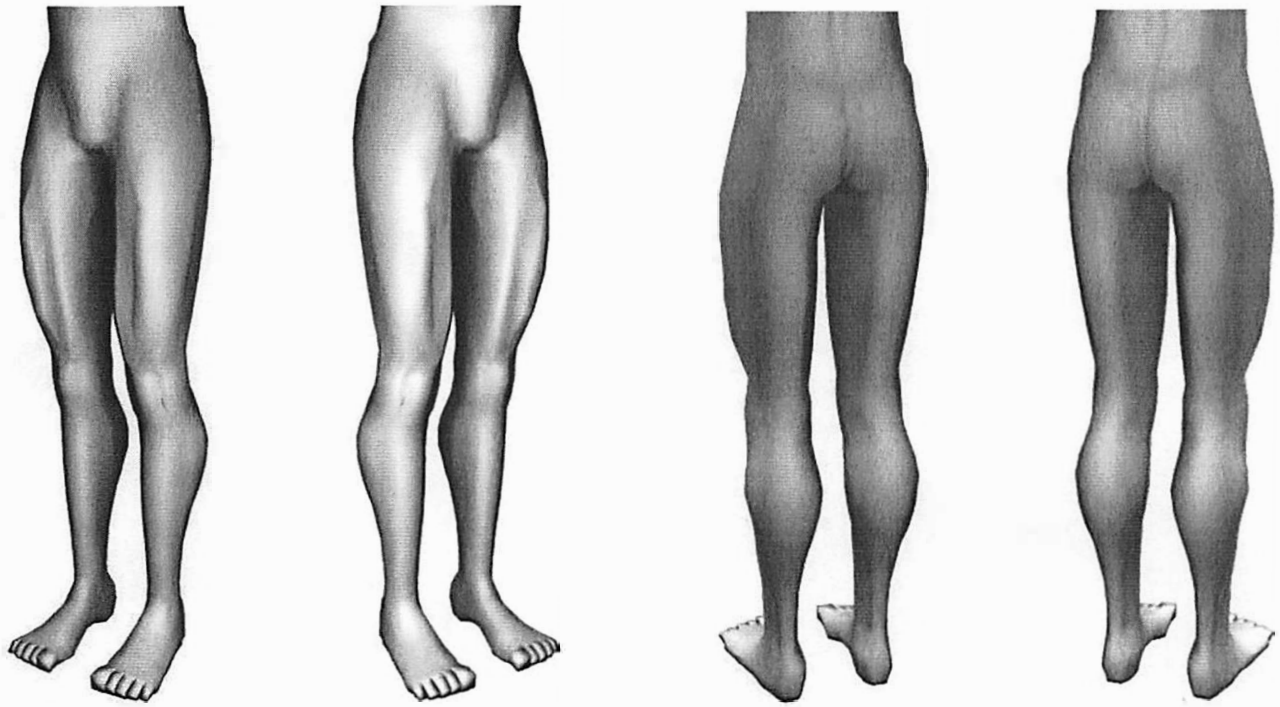
Patient Signature: _____ Date: _____

Physical Exam: *FOR OFFICE USE ONLY*

Vital Signs	Temp:	BP:	HR:	RR:	Weight:

Leg examination:

R	L		R	L		R	L		R	L	
❑	❑	Spider Veins (SV)	❑	❑	Varicose Veins (VV)	❑	❑	Active Ulcers (AU)	❑	❑	Healed Ulcers (HU)
❑	❑	Pigmentation (P)	❑	❑	Numbness (N)	❑	❑	Edema (E)	❑	❑	



Right **Left** **Right** **Left** **Left** **Right** **Left** **Right**

❑ Photograph Taken ❑ Hose measurement Taken: _____

Data (Lab/Imaging Results): _____

_____

ASSESSMENT:

❑ Varicose veins with inflammation	❑ Venous insufficiency	❑ Venous ulcers	❑ VV w other cx (edema, pain, swelling)
❑ Leg pain with venous etiology	❑ Telangiectasias/spider veins	❑ Thrombophlebitis	❑ Asymptomatic VV

Details/other:

_____

_____

PLAN:

❑ Venous Mapping	❑ Endovenous RF	❑ Rule Out DVT
❑ EVLT	❑ US guided sclerotherapy	
❑ *Details/other:*		

_____

_____

Nurses Initials: _____ **Physician Signature:** _____ **Date:** _____

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