Vascular & Endovascular Associates
Comprehensive Vascular Center

PAUL G. BOVE, M.D., F.A.C.S., F.S.V.M.
GRAHAM W. LONG, M.D., F.A.C.S.
MACIEJ R. UZIEBLO, M.D.
SCOTT M. SILVER, M.D.

525 East Big Beaver Road • Suite 125 • Troy, MI 48083 • Phone: 248.688.9860 • Fax: 248.688.9861 • www.michiganvascularsurgeons.com

GENERAL CONSENT TO TREAT

DATE: _____

PATIENTS NAME: _____

DATE OF BIRTH: _____

- **Consent:** I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her assistants participating in my care. This care may include; diagnostic, laboratory or radiology procedures; anesthesia, therapeutic procedures, nursing, hospital or blood transfusions. I understand I will sign an informed consent IF surgery or surgical procedure is recommended.
- **Release of Information:** I authorize Vascular & Endovascular Associates, PLC to release pertinent information and/or copies of medical records for treatment, payment or health care operation purposes. I understand such information may include Human Immunodeficiency Virus (HIV), AIDES Related Complex (ARC) and Acquired Immunodeficiency Syndrome (AIDS), Hepatitis, substance abuse, psychiatric/psychological services records and social work records, if any. See notice of Privacy Practices for further information.
- **Payment:** I assign and authorize payment from my insurance company directly to Vascular & Endovascular Associates, PLC Professional Services for any and all services rendered. I agree to pay, at the time of completed services all charges not covered by my insurance company. I understand that it is my primary responsibility to pay all charges for services rendered irrespective of any disputes or disagreements between myself and the insurance company.
- **No Guarantees:** I am aware that the practice of medicine and surgery is not an exact science and I knowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized. I release Vascular & Endovascular Associates, PLC all responsibility for personal articles which I have with me during the time I am a patient. I understand the office is not responsible for personal articles of value kept in my possession while a patient at the office.

I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this content will be deemed continuing and I am free to withdraw my consent at any time.

Signature of Patient: _____Date: _____

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Vascular & Endovascular Associates, PLC
Release of Information & Statement of Responsibility

I request that payment of all authorized Insurance and Medicare Benefits are made on my behalf to: (circle one)

Paul G. Bove, M.D.
Maciej R. Uzieblo, M.D.
Graham W. Long, M.D.
Scott M. Silver, M.D.

For physician services furnished by _____, to release medical or other information about me to my insurance company and its agent(s) or to the Health Care Financing Administration to determine these benefits or benefits for related services.

I understand that there may be charges that my insurance plan will not pay and I agree to pay _____ _____ for any services not covered.

_____
Signature of patient, parent or legal guardian

_____
Patients name (PLEASE PRINT)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I received a copy of the Notice of Privacy Practices.

_____
Patient or Representative Signature Date

Acknowledgement of receipt of Notice of Privacy Practice was not obtained because:

_____

_____

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ADVANCED DIRECTIVE / LIVING WILL **DATE: _____**

Do you have an Advanced Directive or Living Will? (Circle one)

YES NO

Signature of Patient: _____ Date: _____

If YES – please bring a copy of it with you to your next appointment so we may add it into your Beaumont Health System record.

Thank you

Note: A directive allows you to plan your medical treatment in advance should there ever come a time when you are unable to express your personal health care wishes.

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Vascular & Endovascular Associates
Patient Medical History Form

Name _____ Today's Date _____

DOB _____ Age _____ Sex _____ Allergies _____

Pharmacy Name _____ Phone Number _____

Reason for Visit _____ Primary Care Physician _____

Smoker ☐ Yes How many years? _____ PPD _____ Ready to Quit? ☐ Yes ☐ No

☐ No When did you quit? _____ Never Smoked _____

How much alcohol do you drink? _____ Recreational Drug Use? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No Do you require assistance at home? ☐ Yes ☐ No

Past Medical History

Aneurysm	Y	N	
Bleeding Disorders	Y	N	
Blood Clots	Y	N	
Cancer	Y	N	
Carotid Disease	Y	N	
Diabetes	Y	N	How Long?_____ Diabetic MD _____
Deep Vein Thrombosis	Y	N	
Heart Disease	Y	N	Cardiologist _____
Hypertension	Y	N	
Lipid/Cholesterol	Y	N	
Renal Insufficiency	Y	N	
Stroke	Y	N	
TIA	Y	N	
Varicose Veins	Y	N	

Other _____

Past Surgical History

Abdominal Aneurysm Repair	Y	N	When _____
Carotid Artery Surgery	Y	N	Left/Right/Both When: _____
Open Heart Surgery	Y	N	
Coronary Stent/Angioplasty	Y	N	
Leg Vein Surgery	Y	N	When _____
Leg Artery Surgery	Y	N	When _____
Dialysis Access Graft	Y	N	When _____

Other: _____

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Patient Name: _____

Patient ID: _____

Date: _____

FAMILY HISTORY

Abdominal Aortic Aneurysm	Y	N	Who _____
Bleeding Disorders	Y	N	Who _____
Blood Clots	Y	N	Who _____
Cancer	Y	N	Who _____ Type _____
Diabetes	Y	N	Who _____
Heart Disease	Y	N	Who _____
High Cholesterol	Y	N	Who _____
Hypertension	Y	N	Who _____
Stroke	Y	N	Who _____
Sudden Death	Y	N	Who _____
Varicose Veins	Y	N	Who _____

Other: _____

_____

VEA
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ACCREDITED FACILITY IAC INTERSOCIETAL ACCREDITATION COMMISSION VASCULAR TESTING

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PATIENT INFORMATION				
Last Name:	**First:**	**Middle:**	**Patient ID#:**	**Birth Date:**
Street address:			**Home Phone:**	
P.O. Box:	**City:**		**State:** MI	**ZIP Code:**
Pharmacy Name:			**Pharmacy Phone:**	

IN CASE OF EMERGENCY	
Contact Name:	**Contact Phone:**
Next of Kin Name:	**Next of Kin Phone:**

CURRENT MEDICATION – PRESCRIPTION & OVER-THE-COUNTER		
Name of Current Medication(s):	**Dose of Medication**	**How Often Do You Take This Medication?**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		

ALLERGIES – FOOD, MEDICATION & ENVIORNMENTAL	
Allergic To:	Describe Reaction:

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WORKERS' COMP / AUTOMOBILE ACCIDENT

(Comp / Accident Only)

1) Name: _____

2) Date of Accident: _____ Claim # _____

3) Employer at time of Accident (not applicable for Auto Accident)

_____

4) Phone # _____

5) Street Address: _____

6) City: _____ State: _____ Zip Code: _____

7) Comp Carrier / Insurance Company: _____

8) Phone # _____

9) Street Address: _____

10) City: _____ State: _____ Zip Code: _____

11) Contact Person: _____

12) Phone # _____

Attach Insurance Card Copy (front & back) and Driver License to form

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Sclerotherapy Patient History Form

(for Sclerotherapy patients only)

Name _____Date _____

Referred by Dr. _____

Birth Date _____ Allergies _____

Email address _____

Last LEV (ultrasound of the legs) _____ Right Left Bilateral

Results of LEV reviewed and by which MD? ☐ Yes ☐ No MD _____

Have you had a vein procedure performed in the past? ☐ Yes ☐ No

If yes, what was the procedure and what were the results?

_____

_____

Are you a smoker? ☐ Yes ☐ No (this may increase your risk for blood clots)

If so, how many packs per day? _____

Do you drink alcohol? If so, how many drinks per week? _____

Are you taking?

Aspirin_____

Plavix _____

Coumadin _____

Xarelto _____

Non-steroidal anti-inflammatory drugs_____

Oral Contraceptives _____ (may increase your risk of blood clots)

Are you currently taking antibiotics? ☐ Yes ☐ No

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Do you have leg pain or cramps? If so, which leg? ☐ Left ☐ Right
Is your leg pain or cramping while walking? ☐ Yes ☐ No
Do you have leg swelling? ☐ Yes ☐ No
Do you have leg wounds or discoloration? ☐ Yes ☐ No
Do you have a history of redness or bleeding from veins? ☐ Yes ☐ No

Do you wear compression stockings? If so, for how long? _____

Do you have a history of migraines including optical migraines? ☐ Yes ☐No

Are you pregnant? ☐ Yes ☐No
If pregnant, are you breastfeeding? ☐ Yes ☐No

Do you have a history of any of the following?

Previous anaphylaxis to proposed sclerosants	Yes	No
DVT	Yes	No
Peripheral vascular disease	Yes	No
Thrombophilia	Yes	No
Uncontrolled asthma	Yes	No
Skin disease (systemic disease)	Yes	No
Acute Superficial Vein Thrombosis	Yes	No
Blood clots in the lungs	Yes	No
Heart Disease	Yes	No
Heart valve disease	Yes	No
Arterial Disease	Yes	No
High Blood Pressure	Yes	No
Lung disease	Yes	No
Anesthesia problems	Yes	No
HIV infection	Yes	No
Bleeding disorder	Yes	No
Diabetes	Yes	No
Hepatitis	Yes	No
Arthritis	Yes	No
Auto-immune disease (i.e., lupus)	Yes	No
Keloids or excessive scar formation	Yes	No

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Have you ever had any of the following treatments?

Vein removal (phlebectomy)	R	L
Vein stripping	R	L
Vein tied off	R	L
Vein injection	R	L
Vein ablation (EVLT, laser or RF)	R	L

Past Surgical History

Please list the type and date of previous surgeries:

_____

_____

_____

Please list problems affecting any other medical systems:

_____

_____

_____

Family History

Please list vein problems that affect your family members (varicose, spider veins, blood clots, or swollen legs):

Father: _____

Mother: _____

Other: _____

Reviewed By: _____ Date: _____