



Glen W. Simons, MD 3229 Summit Square Place, Suite 150, Lexington, KY 40509
Phone: (859) 455-VEIN (8346) Fax: (859) 455-8866

Dear Patient:

Dr. Glen Simons and Staff would like to welcome you to our practice.

Please complete the attached forms prior to your initial visit and ***please mail them back before your appointment.***

Please DRINK a minimum of 16oz of WATER 1-2 hours prior to your appointment!

Please bring your shortest loose-fitting shorts to all your appointments. Avoid wearing jean shorts.

We will call to confirm your appointment 2 days prior to your scheduled appointment. Please make sure that we have a current phone number on file. **If we are unable to confirm your appointment, your appointment will be cancelled. (See cancellation policy, included).**

Should you need to reschedule your appointment, please provide forty-eight hour advance notice. Patients who fail to provide advance notice twice may not be rescheduled.

Please be prepared to pay all co-pays, deductibles, and/or other fees at the time of service. Feel free to call us with any questions or concerns that you may have at 859-455-8346. We look forward to your visit.

Sincerely,

Dr. Glen Simons and Staff

Patient Information:

Name: _____ Date of Birth: _____

Address: _____ Social Security: _____

City: _____ State: _____ Zip code: _____

Home Telephone: _____ Cellular Telephone: _____

Email address _____ Work Telephone: _____

Male Female / Single Married Widowed Divorced / Employed Retired Disabled

Employer: _____ Work Telephone: _____

Address: _____ City: _____ State: _____ Zip code: _____

Occupation: _____

Emergency Contact Person: _____ Telephone: _____

Pharmacy: _____ Telephone: _____

Family Physician _____

Referred By: Physician _____ Employee Friend Insurance Company
 Internet Magazine Newspaper Patient Phone Book Radio Television Other

Insurance Information:

Primary Insurance: _____ Responsible Party: _____

Policy Number: _____ SSN Responsible Party: _____

Group Number: _____

Policy Holder's Name: _____ Date of Birth of Policy Holder: _____

Release of Information:

The information provided herein is accurate and correct to the best of my knowledge. I authorize the release of any medical information requested by my insurance company to assist with the determination of my benefits. I consent to the release of pertinent medical records to all consulting physicians participating in my treatment and care. I hereby authorize evaluation and treatment by Dr. Glen W. Simons. This authorization shall remain valid until I provide written notice revoking said authorization.

Signature: _____ Date: _____

Medical History:

Name: _____ Male Female Date of Birth: _____

Height: _____' _____" Weight: _____ lbs

Briefly describe your current symptoms: _____

How long have you had this problem: _____ Pain No pain Severity (0=none to 10=severe): _____

Location: Left Right Both Groin Thigh Knee Calf Ankle Foot Other: _____

Onset: Predictable Unpredictable Exercise Elevation Sleep Cold Heat Position Activity

Made worse: By standing By standing for long periods of time By wearing compression hose In spite of wearing hose

Made better: By resting legs By walking By elevation With heat With cold By wearing compression hose

Do you wear compression hose? Yes No If "yes" how long did you or have you been wearing: _____

Do you take analgesics (Motrin, Advil, Tylenol, Aleve, etc) __ Yes __ No How often: _____ For how long: _____

Discoloration: Bruised Red Purple Rash Brown Ulcerated Other: _____

History: Deep Venous Thrombosis Pulmonary Embolus Superficial Phlebitis Previous venous or arterial surgery

Varicose or spider vein treatments Laser Sclerotherapy Surgery: _____

Please check and/or list all illnesses for which you have received medical attention:

- None Bleeding disorders Depression Hepatitis Seizures
- Anemia Blood Clots Diabetes High Blood Pressure Stroke
- Angina Cancer Diverticulitis Kidney disease Thyroid disease
- Arthritis Cirrhosis Emphysema Low Blood Pressure Ulcer disease
- Asthma Chronic bronchitis Heart attack Migraine headaches Tuberculosis
- Bladder infections Crohn's disease Heart murmur Mitral Valve Prolapse Ulcerative Colitis

Other: _____ Other: _____

Please check and/or list all surgeries:

- None Cataracts Hernia Orthopedic Surgery Tonsillectomy
- Appendix Colon Surgery Hysterectomy Pacemaker Tubal Ligation
- Breast Surgery D & C Lung Surgery Prosthesis Ulcer Surgery
- Cardiac cath Gall bladder Open Heart Surgery Thyroid Surgery Vascular Surgery

Other: _____ Other: _____

Please list all medications (Including herbal and OTC) you currently take: None

Drug allergies: None

History of allergic reaction to iodine, shellfish, or X-ray contrast: No Yes Type of reaction: _____

Social/Family History:

Name: _____ Birthplace: _____

Tobacco: None Quit Cigarettes, number of packs per day: _____, number of years: _____ Cigars Pipe Snuff

Coffee: None Number of cups per day: _____ Tea: None Number of cups per day: _____

Alcohol: None Beer amount weekly: _____ Wine, amount weekly: _____ Hard liquor, amount weekly: _____

Father: Alive, current health problems: _____

Deceased, cause of death: _____

Mother: Alive, current health problems: _____

Deceased, cause of death: _____

Brothers: _____

Sisters: _____

Father's family: _____

Mother's family: _____

Review of Systems

Do you now have or have you had within the past year:

Weakness or paralysis Yes No

Tire easily or weakness Yes No

Recent weight changes Yes No

Change in appetite Yes No

Sensitivity to cold or heat Yes No

Headaches Yes No

Easy bleeding or bruising Yes No

Double vision Yes No

Blurred vision Yes No

Do you wear glasses or contacts Yes No

Date of last eye examination _____

Ring in the ears Yes No

Ear pain Yes No

Decrease in hearing Yes No

Frequent nosebleeds Yes No

Persistent hoarseness Yes No

Sore throat Yes No

Lump in breast Yes No

Discharge from nipple Yes No

Chronic or frequent cough Yes No

Shortness of breath Yes No

Bloody sputum Yes No

Wheezing Yes No

Chest pain or discomfort Yes No

Purple fingers or lips Yes No

Swelling of hands, feet, or ankles Yes No

Difficulty in breathing Yes No

Palpitations or fluttering of the heart Yes No

Leg cramps on walking or at night Yes No

Enlarged veins Yes No

Difficulty swallowing Yes No

Heartburn Yes No

Frequent belching Yes No

Abdominal cramping Yes No

Nausea Yes No

Vomiting Yes No

Rectal bleeding Yes No

Black tarry stools Yes No

Dark urine Yes No

Frequent urination Yes No

Increase in thirst Yes No

Painful urination Yes No

Blood in urine Yes No

Lack of sex drive Yes No

Hemorrhoids Yes No

Joint pain or stiffness Yes No

Swollen joints Yes No

Muscle cramps or spasms Yes No

Sleeplessness Yes No

Seizures Yes No

Depression Yes No

Memory loss Yes No

Poor coordination Yes No

Dizziness or fainting spells Yes No

Men:
Discharge from penis Yes No

Pain or lump in testicles Yes No

Impotence Yes No

Women:
Age period began _____

Last menstrual cycle _____

Date of last pelvic examination _____

Date of last mammogram _____

Number of pregnancies _____

Birth control pills Yes No

Hormone replacement therapy Yes No

Acknowledgement of Receipt of Privacy Notice and Disclosure Notice

I have been presented with a copy of Glen W. Simons, MD, PSC's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ **Witnesses by:** _____

I request the following restriction(s) concerning the use of my personal medical information:

Our office, at the discretion of the medical staff, routinely discloses information such as, but not limited to, appointment time and date, laboratory results, account information (financial), and medication information to family members (i.e.: spouse, parent, or sibling). Information of extremely private nature is never disclosed to anyone other than the patient (i.e. STD screenings, abortion history, etc.). Please indicate below should you wish information shared or restricted:

	YES	NO
Share appointment information with spouse	<input type="checkbox"/>	<input type="checkbox"/>
Share appointment information with family members	<input type="checkbox"/>	<input type="checkbox"/>
Share treatment information with spouse	<input type="checkbox"/>	<input type="checkbox"/>
Share treatment information with family members	<input type="checkbox"/>	<input type="checkbox"/>
Share medication information with spouse	<input type="checkbox"/>	<input type="checkbox"/>
Share medication information with family members	<input type="checkbox"/>	<input type="checkbox"/>
Share financial information with spouse	<input type="checkbox"/>	<input type="checkbox"/>

Other allowed disclosure or restriction: _____

Signature: _____ Date: _____

Note: the patient may change this information and/or restriction at anytime.

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By: (name and title): _____



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APPOINTMENT CANCELLATION POLICY

Appointment times represent time set aside by Dr. Simons to address your specific medical needs. The care of our patients is the primary goal at Kentucky Vein Care. Due to an increase in patient late cancellations and no shows for scheduled appointments, we are having difficulty seeing the patients that need our care.

Therefore, our office is regrettably instituting a new policy. **A charge of \$50.00 will be billed to the patient when a scheduled office visit appointment is not cancelled or rescheduled 48-hours in advance.** A charge of \$500.00 will be billed to the patient when a scheduled surgical procedure is not cancelled or rescheduled 48-hours in advance. This fee is not covered by your insurance and payment is the responsibility of the patient and must be paid prior to rescheduling another visit.

PLEASE BE COURTEOUS ENOUGH TO CANCEL YOUR APPOINTMENT 48-HOURS IN ADVANCE TO ALLOW ADEQUATE TIME FOR THE STAFF TO SCHEDULE ANOTHER PATIENT IN YOUR TIME SLOT.

Your signature below indicates your understanding of this policy and your financial obligation to pay for the appointment(s) not cancelled in advance.
