MONTANA VEIN CLINIC
905 Highland Boulevard, Suite 4450
Bozeman, MT 59715
Phone: (406) 414-5037

PLEASE HAVE ALL PAPERWORK FINISHED PRIOR TO COMING FOR YOUR APPOINTMENT!

PATIENT NAME:

APPT DATE/TIME: PLEASE ARRIVE BY:

ULTRASOUND APPT DATE/TIME:

Dear Patient:

Thank you for choosing the Montana Vein Clinic for your medical care. We have enclosed items for your review and ask you to complete them PRIOR to your appointment. We ask that you please arrive 15 minutes prior to your appointment time. This will allow us adequate time for the check-in process. Please have the enclosed forms completed, front and back, prior to your visit so you and your provider can stay on schedule. If you are unable to make your appointment, please give our office 24 hours notice.

The items we have enclosed:

Patient Demographics:
This form provides necessary contact and billing information. We would be happy to submit your claims to any insurance. We will scan your insurance card(s) into our system as long as it is current and has complete information.

Medical History Questionnaire & Varicose Vein Questionnaire:
These forms gather the necessary data for us to process your electronic health record. It also provides information to Dr. Grace regarding your current health and past history. Please be sure all the information is filled out COMPLETELY.

MyChart Authorization:
MyChart offers patients of Montana Vein & Surgical a secure way to view parts of their healthcare records online. Please read this form thoroughly before signing to request access to view your medical records on MyChart.

HIPAA Form:
We will have you fill out this form in the office if it isn't already on file. Please provide name(s) of anyone whom you would like us to be able to discuss your medical information with. We cannot release ANY information to anyone that is not listed. No exceptions!

IMPORTANT INFORMATION YOU NEED TO KNOW PRIOR TO YOUR APPOINTMENT!
We have enclosed information regarding compression stockings and other tests that might be needed prior to any varicose vein treatment. This is considered a "conservative treatment" measure that your insurance will be looking for before approving any procedures. Please read through this carefully and get yourself a pair of compression stockings as soon as you can.

We encourage you to call our office with any questions about the information or forms you have received. We look forward to seeing you!

Sincerely,
The Montana Vein Clinic Staff

ANDREW W. GRACE, M.D., F.A.C.S.

IMPORTANT INFORMATION

COMPRESSION STOCKINGS

Insurance companies require a patient to try what they call "conservative treatment" or "non-surgical treatment" prior to approving or paying for treatment for venous insufficiency.

Insurance companies consider "conservative treatment" to be:

1. Use of **compression stockings**, for a period of three (3) months.

It *MAY* also include the following:

2. Use of over the counter type pain relievers.
3. Mild exercise.
4. Elevation of your legs when able.
5. Maintaining a healthy weight.

OVER-THE-COUNTER COMPRESSION STOCKINGS:

To begin your "conservative treatment" Dr. Grace **STRONGLY** encourages the use of compression stockings on a daily basis. You can purchase these stockings over-the-counter at CVS or Wal-Mart. This type of stocking may work perfectly well for you and are much less costly ($10-$20) than the "Graduated compression stockings".

GRADUATED COMPRESSION STOCKINGS:

You may need more support in the stockings than what the over-the-counter stockings can give you. If this is the case, you will be provided with a prescription for graduated compression stockings. These are special measured for you at Blue Bird Medical or Medical Arts Pharmacy in Bozeman. These are more costly ($50-$80) but they are a very efficient compression and are specifically measured and fit for you.

Please be aware that you will need to purchase **ANOTHER** pair of stockings which are higher in compression and thigh-high, for use **AFTER** your varicose vein procedures. Dr. Grace requests that you purchase this pair at Blue Bird Medical or Medical Arts Pharmacy. These are $80-$100 and Insurance companies normally **DO NOT** reimburse you for the stockings.

THE SOONER YOU CAN GET INTO A PAIR OF COMPRESSION STOCKINGS THE BETTER!

ULTRASOUND EXAM

Dr. Grace may need additional testing to "map the anatomy of your superficial system" by ordering an ultrasound, because that is where the problem begins with varicose veins. There are additional costs with this test that are through Bozeman Deaconess Hospital **AND** Advanced Medical Imaging. Your insurance company will require this test to prove that your treatment will be "medically necessary" versus "cosmetic". Once Dr. Grace sees you for your consultation he will order this if he feels it is necessary.

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PATIENT QUESTIONNAIRE – FOR ADULTS

A. DEMOGRAPHIC INFORMATION

LAST FIRST MI

DATE OF BIRTH AGE

REASON FOR VISIT TODAY

Who is your Primary Care Provider (M.D., D.O.):

Do you have any special needs? YES / NO

Vision Impaired: YES / NO Hearing Impaired: YES / NO Wheelchair: YES / NO

Needs Interpreter: YES / NO Other:

B. ALLERGIES

Do you have any:

Seasonal Allergies? YES / NO known allergies. If Yes – please list below.

Medication Allergies? YES / NO known allergies. If Yes – please list below.

ALLERGY	REACTION

C. MEDICATIONS

MY PREFERRED PHARMACY CITY

Are you currently on any medications? YES / NO

Please list any medications that you are presently taking.

Please list any natural or Alternative Therapies (chiropractic, magnets, massage, over the counter preparations, etc.)

MEDICATION NAME	DOSE	FREQUENCY	PRESCRIBING M.D.

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D. PAST MEDICAL ILLNESS

Please check the box below if you HAVE OR HAVE HAD:

Angina (Chest pain)		CVA (Stroke)		Liver disease	
Anxiety		COPD (Emphysema)		Macular Degeneration	
Arthritis		Crohn's Disease		Malignant Hyperthermia	
Asthma		Diabetes		MRSA	
Atrial Fibrillation		DVT		Myocardial infarction (Heart attack)	
Bleeding disorder		Gallbladder Disease		Pulmonary Fibrosis	
Blood clots		GERD		Radiation	
Cancer		Glaucoma		Renal Disease	
Cardiac Arrest		Hepatitis C		Seizure Disorder	
Cardiac Dysrhythmias		HIV/AIDS		Sleep Apnea	
Cardiac Valve Disease		Inflammatory Bowel Disease		Thyroid Disease	
Chronic Pain		Hypertension (High blood pressure)		Other:	

E. PAST SURGERIES OR INJURIES

Please list your past surgeries or injuries and what year they occurred:
No surgeries. ☐ No injuries. ☐

Surgery/Injury/Year	Surgery/Injury/Year	Surgery/Injury/Year

F. FEMALES ONLY

YES / NO

Last period date | Days between | Regular | Age at onset

Current Birth Control | Former Birth Control

Number of pregnancies | Number of live births | Age at first birth

Did you breast feed?

G. TOBACCO/ALCOHOL USE:

Do you use tobacco? YES / NO | Former user? YES / NO

Packs per day | Cans(for chew) per day

If you are a former tobacco user, please tell us when you stopped using
How many years did you use tobacco?

Do you drink alcohol? YES / NO | Number of drinks per week:

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H. SOCIAL HISTORY: EMPLOYMENT/OCCUPATION

Employed: YES / NO Retired? YES / NO

Place of employment

Occupation

I. MARITAL STATUS:

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

With whom do you reside

J. FAMILY HISTORY

Do you have any family history of the following? Please check if appropriate.

CONDITION	MOTHER	FATHER	BROTHER	SISTER	DAUGHTER	SON	OTHER
Alcoholism							
Alzheimer's/Dementia							
Asthma							
Bipolar Disorder							
Bleeding Tendencies							
Blood clots							
Cancer: Type:							
Depression							
Diabetes: Type:							
Heart Attack/Disease							
High cholesterol							
Hypertension							
Seizure Disorder							
Stroke							
Sudden Death (Unexplained)							
Other							

HIPAA

Health Insurance Portability and Accountability Act

Authorization to Discuss Medical Health Information to your friends' and/or family involved with your medical care. This authorization applies for all of Bozeman Deaconess Health Group clinics and providers.

To whom may we disclose your medical information? Please list below.

Name	Relationship	Phone Number

Primary Emergency Contact

Name: _____ DOB: _____

Address: _____

Phone: _____ Relationship to you: _____

This authorization is in force until it is revoked in writing.

Primary Physician/Provider: _____

Print Patient Name: _____ DOB: _____

Signature: _____ Date: _____

To be scanned under Medical Authorization
Information to be data entered in EMR/HIPAA field.

PATIENT LABEL:

Bozeman Deaconess
HEALTH GROUP

Patient Name: **Birthdate:** **Age:**

VARICOSE VEIN HISTORY

Do you have varicose veins or problems in your:. . . . . LEFT LEG ☐ RIGHT LEG ☐

How long have you had varicose veins? . . . . . _____

Have your veins gotten worse in recent months? . . . . . YES ☐ NO ☐

Have you ever had a blood clot or phlebitis in either leg? . . . . . YES ☐ NO ☐

If yes, when and which leg? _____

If yes, did you take a blood thinning medication after the blood clot/phlebitis? YES ☐ NO ☐

Have you ever had any skin ulcerations (skin breakdown)? . . . . . YES ☐ NO ☐

If yes, which side and where? _____

Have you ever had any skin discoloration or skin darkening in your legs? . . . YES ☐ NO ☐

If yes, when and where? _____

Have you ever had any trauma to either leg (broken bones, etc)? . . . . . YES ☐ NO ☐

If yes, please describe: _____

Have you ever had any surgery on either leg? . . . . . YES ☐ NO ☐

If yes, please describe: _____

CURRENT SYMPTOMS

Do you experience any of the following symptoms in your legs?

Aching/Pain . . . . . YES ☐ NO ☐

Heaviness . . . . . YES ☐ NO ☐

Tiredness/Fatigue . . . . . YES ☐ NO ☐

Itching/Burning . . . . . YES ☐ NO ☐

Swollen Ankles . . . . . YES ☐ NO ☐

Leg Cramps . . . . . YES ☐ NO ☐

Restless Legs . . . . . YES ☐ NO ☐

Throbbing . . . . . YES ☐ NO ☐

Do you elevate your legs to relieve discomfort? . . . . . YES ☐ NO ☐

Do you wear compression hose prescribed by a physician? . . . . . YES ☐ NO ☐

If yes, do they provide relief? . . . . . YES ☐ NO ☐ PARTIALLY ☐

Do you wear light support hose? . . . . . YES ☐ NO ☐

If yes, do the support hose provide relief? . . . . . YES ☐ NO ☐ PARTIALLY ☐

Do you have a problem walking? . . . . . YES ☐ NO ☐

If yes, how does it affect you? _____

Do you stand much at home? . . . . . YES ☐ NO ☐

Do you stand much at work? . . . . . YES ☐ NO ☐

Does standing affect or bother your legs? . . . . . YES ☐ NO ☐

If yes, please describe: _____

PRIOR VEIN TREATMENTS

Have you ever had your veins evaluated before? . . . . . YES ☐ NO ☐

If yes, when and where? _____

Have you ever had any tests done on your veins?. . . . . YES ☐ NO ☐

Have you ever had any vein injections? . . . . . YES ☐ NO ☐

If yes, when and which leg? _____

Have you ever had any vein stripping surgery? . . . . . YES ☐ NO ☐

If yes, when and which leg? _____

Have you ever had any laser treatments on either leg? . . . . . YES ☐ NO ☐

If yes, when and which leg? _____

Andrew W. Grace, M.D., F.A.C.S.
Board Certified
General Surgery & Phlebology

MONTANA VEIN & SURGICAL CLINIC, PLLC

905 HIGHLAND BOULEVARD, SUITE 4450
BOZEMAN, MT 59715

For Appointments: (406) 414-5037

Fax: (406) 414-5295

Today's Date: _____

Referring MD: _____ PCP: _____

How did you hear about our clinic? _____

PATIENT INFORMATION

Patients Full Name: _____ Male/Female (Please circle one)
First M.I. Last

Date of birth: _____ Age: _____ Social Security Number: ___ – ___ – ____

Home Address: _____
Street City State Zip Code

Mailing Address: _____
PO Box/or "same as above" City State Zip Code

E-mail: _____

Home Phone #: ( ) Cell Phone #: ( )

How do you prefer we contact you? Cell Phone Home Phone Work Phone Email Patient Portal

PLEASE CIRCLE BEST ANSWER

MARITAL STATUS:	SINGLE	MARRIED	SEPARATED	DIVORCED	WIDOWED	CHILD
ETHNICITY:	HISPANIC OR LATINO	NON-HISPANIC OR NON-LATINO	UNKNOWN			
RACE:	AMERICAN INDIAN/ALASKA NATIVE	ASIAN	BLACK/AFRICAN AMERICAN			
	NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER	WHITE	UNKNOWN	OTHER		

Patients Employer: _____ Occupation: _____

Work phone #: ( ) How long with employer: _____ F/T or P/T

SPOUSE

Spouse's Full Name: _____ Spouse's Date of Birth: _____
First M.I. Last

Spouse's Social Security Number: ___ – ___ – ____ Spouse's Phone #: ( )

INSURANCE INFORMATION

Is this work related? Yes/No (If Yes, please see receptionist)
Please circle one

Do you have health insurance? Yes/No _____ Name of policy holder: _____

Policy holder's date of birth: _____ Relation: _____

SS# of Policy Holder: ___ – ___ – ____

IF YOU HAVE INSURANCE: WE WILL NOT SUBMIT CLAIMS TO YOUR INSURANCE WITHOUT A COPY OF YOUR INSURANCE CARD! IT IS YOUR RESPONSIBILITY TO GET THIS INFORMATION TO US!

MINORS:

If patient is a minor:
Parents/Guardian Names: _____

Mailing address: _____
Street/PO Box City State Zip Code

Phone number: ( ) SS# Parent/Guardian: ___ – ___ – ____

EMERGENCY CONTACT: _____
(Name) (Phone #) (Zip Code) (Relation)

My Chart Sign-Up Form

Thank you for your interest in My Chart, an easy-to-use Internet tool that provides you quick and secure online access to your health information from anywhere at any time.

Instructions for Completing this Form

To sign up for access to your health information in My Chart, please complete this Sign-Up Form. If you would like to access to your child or another adult's My Chart information, please ask for the appropriate forms.

Your information: (All sections required – please print clearly.)

Name (*last, first, middle initial*): _____

Last 4 Digits of Social Security Number: _____ Date of Birth: _____

Email Address: _____ Phone Number: _____

Primary Physician: _____

My Chart Terms and Agreement

- I acknowledge and agree what while My Chart contains a "Message Center" for patients age 18 and older, such messaging shall not be used for medical emergencies. Rather, I will call 911 in the event of a medical emergency.
- I understand that My Chart is intended as a secure online source of confidential medical information. If I share My Chart ID and password with another person, that person will be able to view my health information or my child's health information, and information about anyone who has authorized me as a My Chart proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that My Chart contains selected, limited medical information for a patient's medical record and the My Chart does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested.
- I understand that my activities within My Chart may be tracked by computer audit and that entries I make may become part of the medical record.
- I understand that access to My Chart is provided by Bozeman Health as a convenience to its patients and that Bozeman Health has the right to deactivate My Chart at any time for any reason. I understand that use of My Chart is voluntary and I am not required to use My Chart or to authorize a My Chart proxy.
- **By signing below, I acknowledge that I have read and understand this My Chart Sign-Up Form and I agree to its terms.**

_____ / _____ / _____

Signature of Patient/Authorized Person **Relationship to Patient** **Date**