The Premier Vein Center
Evan Oblonsky MD
1051 W. Rand Road, Suite 104
Arlington Heights, IL 60004
Tel: 847-590-8888 Fax: 841-559-0111

PATIENT INFORMATION (PLEASE PRINT)

Patient Name:		Home Phone:	
Nickname:		Work Phone:	
Guardian:		Cell Phone:	
Date of Birth:		Best Number:	
Sex:		License / ID#	
		Contact Email:	
Address:		Emergency Contact:	
City:		Emergency Phone:	
State:			
Zip Code:		Primary Care MD:	
Country:		2nd Physician	
2nd Address:		Referring Physician:	
Marital Status:		How did you hear	
Spouse (If appl)		about us?	
Pharmacy:			

HIPAA Choices:

Did you receive a copy of the HIPAA Notice? Yes ___ No ___ Allow Voice Msg? Yes___No___

Allow Postal Mail? Yes___ No___ Who may we leave a message with? _____

Allow eMail? Yes___ No___ Allow SMS (text message?) Yes___ No___

Allow Calls to Cell? Yes___ No___

Occupation:		Employer Address:	
Employer:		City / State:	
(Leave blank if inapplicable)		Zip Code:	

Language:		Need Interpreter:	Yes:_____ No:_____
Race:			
Ethnicity:		Seasonal Resident:	Yes:_____ No:_____

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PATIENT INFORMATION (PLEASE PRINT)

Primary Insurance Provider: (Please provide a copy of your card)

Insurer: _____ Subscriber: _____

Plan Name: _____ (If self - do not complete the following lines)

Effective Date: _____ Relationship: _____

Policy Number: _____ Date of Birth: _____

Group Number: _____ Soc. Sec. # _____

Co Pay: _____ Sex: _____

Subscriber Subscriber Address: _____

Employer: _____ City: _____

Address: _____ State: _____

City: _____ Zip Code: _____

State: _____ Country: _____

Zip Code: _____ Subscriber Tele#

Country: _____

Secondary Insurance Provider: (Please provide a copy of your card)

Insurer: _____ Subscriber: _____

Plan Name: _____ (If self - do not complete the following lines)

Effective Date: _____ Relationship: _____

Policy Number: _____ Date of Birth: _____

Group Number: _____ Soc. Sec. # _____

Co Pay: _____ Sex: _____

Subscriber Subscriber Address: _____

Employer: _____ City: _____

Address: _____ State: _____

City: _____ Zip Code: _____

State: _____ Country: _____

Zip Code: _____ Subscriber Tele# _____

Country: _____

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PATIENT INFORMATION (PLEASE PRINT)

Medical Information Release and Assignment of Benefits:

Evan Oblonsky MD is hereby authorized to furnish information to insurance carriers concerning my illness and treatments, and to collect all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered or paid by insurance. I am also responsible for any Deductible, Copay, and/or Coinsurance at the time services are rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. I have the right to revoke this authorization at any time in writing.

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

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PATIENT HISTORY

Patient Name: _____

Patient is here for: _____

_____

Chief Complaint:

___ Pain	___ Inflammation	___ Spider Veins
___ Swelling	___ Skin Rash or discoloration	___ Reticular Veins
___ Varicose Veins	___ Bleeding	___ Numbness or tingling in legs
___ Ulceration	___ Reddened/hard knot in vein	___ Burning
___ Restless Leg Syndrome	___ Leg Cramps	___ Heaviness

Other: _____

Which Leg: ___ Right ___ Left ___ Both

How Long: _____

Previous Treatments: _____

_____

_____

Worse With:

___ Sitting	___ Walking	___ Menstrual Cycle
___ Standing	___ Working	___ Lying Down
___ Beginning of Day	___ End of Day	___ Pregnancy

Other: _____

Improved By:

___ Elevation	___ Compression Hose	___ Fluid Pills
___ Rest	___ Tylenol/Motrin Equivalent	___ Walking
___ Beginning of Day	___ End of Day	

Other: _____

Social History:

Alcohol: ___ Never ___ Rare ___ Occasional/Social ___ Daily

Smoking: ___ Never ___ Quit > 10 yrs ___ Quit 1-10 yrs ___ Quit < 1 yr ___ Current Smoker

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PATIENT HISTORY (continued)

Past Surgeries:

___ Coronary Atrtery Bypass Other: _____
___ Angioplasty / Stenting _____
___ Peripheral Vascular Surgery _____

Past Medical History:

___ Coronary Artery Disease Other: _____
___ High Cholesterol _____
___ High Blood Pressure _____
___ Diabetes _____
___ Peripheral Vascular Disease _____
___ Varicose Veins _____

Allergies:

Please List: _____
_____
_____
_____
_____

Family History:

___ Coronary Artery Disease Details: _____
___ High Cholesterol Details: _____
___ High Blood Pressure Details: _____
___ Diabetes Details: _____

Other: _____
_____

Current Medications:

Please List: _____
_____
_____
_____
_____

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PATIENT HISTORY (continued)

Review of Systems: Please check all that apply.

Skin:
___ Itching
___ Hives
___ Bruising
___ Bleeding

Eyes:
___ Vision changes or loss
___ Double Vision

Ears:
___ Hearing aids
___ Hearing loss
___ Pain
___ Discharge
___ Ringing
___ Infections

Nose:
___ Nosebleeds
___ Discharge
___ Infections
___ Pain

Mouth/Throat:
___ Cavities
___ Dentures
___ Bleeding Gums
___ Sores / Lesions
___ Hoarseness

Respiratory:
___ Cough
___ Blood
___ Shortness of breath
___ Asthma
___ Emphysema
___ Tuberculosis
___ Pneumonia
___ Bronchitis

Cardiovascular:
___ Chest Pain
___ Palpitations
___ Shortness of breath
___ when sleeping
___ when walking
___ Legs swelling
___ Cramps
___ Varicose veins
___ Color changes
___ Legs/feet

Gastrointestinal:
___ Vomitting
___ Constipation
___ Diarrhea
___ Heartburn
___ Blood in stool
___ Changes in stool
___ Difficulty / pain
___ in swallowing
___ Jaundice
___ Liver Disease
___ Gallbladder Disease

Genitourinary:
___ Urine frequency
___ Pain
___ Bloody urine
___ Incontinence

Hematology / Lymphatic:
___ Anemia
___ Sickle Cell
___ Hemophilia
___ Swollen Glands
___ Night Sweats
___ Itching

Neurological:
___ Headaches
___ Dizziness
___ Numbness
___ Falls
___ Tremors
___ Stroke / TIA's
___ Loss of memory
___ Problems with gait

Psychiatric:
___ Depression
___ Anxiety
___ Bipolar

Endocrine:
___ Increased thirst
___ Increased urine
___ Intolerance to heat
___ Intolerance to cold
___ Diabetes
___ Hot flashes

Allergy / Immune:
___ AIDS
___ Hepatitis B
___ Hepatitis C

Musculoskeletal:
___ Weakness
___ Paralysis
___ Stiffness
___ Joint Pain
___ Swelling
___ Arthritis
___ Gout

Neck:
___ Goiter
___ Pain
___ Thyroid problems

Patient Signature: _____ Date: _____