## **New Patient Registration:**

Patient Name:	Last Na	me		First Na	me		Middle Initial
Social Security Number: (Medical Appointments Only)		Date of Birth:			Sex: M / F (Please Circle One)		
Marital Status:		Race (Optional):			Ethnicit	y (Optio	nal):
S M D W							
(Please Circle One) Street Address:							
Street Address.							
City:				State:		Zi	p:
Primary Phone				Seconda	ary Phon	е	
Home / Cell / Wo	ork				Cell / Wo	ork	
(Please Circle One)				(Please Ci	rcle One)		
Email:						Fmai	Appointment Confirmations
(Required for Insura	nce					Liliai	YES NO
and HIPPA Portal – N	lot						(Please Circle One)
shared other entities	5)						
Would you like t	o receive	our newsletter?				Tovt	Appointment Confirmations
Would you like to receive our newsletter?  YES NO					ΙΕΛί	YES NO	
(Please Circle One)					(Please Circle One)		
Employment In	formatio	on:					
Employer Name:				Occ	upation:		
Employer Addres	ss:			Emp	oloyer Ph	none:	
City:				Stat	e:		Zip:
Emergency Contact Information:							
(Name someone we can contact if needed while you are at our office – We must be able to share your medical information.)							
Emergency Contact Name:							
Contact Phone N	lumber:			Rela	ationship	:	
					·		

## **Insurance Information:**

Primary Insurance Informati	ion	Secondary Insurance Information			
Insurance Company Name:		Insurance Company Name:	Insurance Company Name:		
Member ID Number:		Member ID Number:			
Group Number (Name):		Group Number (Name):			
Name of Policy Holder:		Name of Policy Holder:			
Policy Holder SS#	Policy Holder – DOB	Policy Holder SS#	Policy Holder – DOB		
What type of plan do you ha	ave? (Please Circle)	What type of plan do you h	ave? (Please Circle)		
HMO / POS /	PPO	HMO / POS /	PPO		
If you need a referral, it is yo	our responsibility as the pa	tient to obtain a referral from y	our primary care physician.		
Please bring your referral po	aperwork to your first appo	intment, or have it faxed to our	office (636-278-1670)		
Center, medical benefits ma me. I authorize any holder of provider or their agents any understand that I am finance	nce benefit plan to pay dir ide either to me or on my l of medical or other health i information needed to de ially responsible for any ch Group d/b/a Laser Lipo ar	rectly to Lakeview Medical Groubehalf to Dr. Thomas F. Wright of the nformation about me to release termine these benefits or benefiarges not covered by my insurand Vein Center to release any arbition to secure payment.	for any services furnished to e to my health insurance fits for related services. I ance provider. Further, I		
Signature of Responsibl	e Party		Date		

### **Medical Information:**

Wieulcai Illioi Illation.						
Primary Care Physician:	Phone Nun	nber:				
, ,						
Pharmacy:	Phone Nun	nber:				
Are you currently being treated for any medical conditions? YES NO						
If yes, who is the treating physician and what are	you being treated	d for: Physician:				
Condition:						
Condition:						
Medications – List all medications you are taking	including vitamin	is and herbal remedies:				
Medication	Dosage	How Often Do You Take This Medication?				
	Dosage	The Work of the Park of the Work of the Park of the Pa				
	•					
List All Allergies:						
Medications		Other Allergies				
List All Surgeries and Dates:						
Surgery		Date / Year (Approx.)				
5.00		-, -: ( , , , -: , ,				

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Do you drink alcoholic beverages?	NO	YES (#/Week	)
Do you now, or have you ever used to	bacco?	NO YES (Packs/Week	)
Quit Date (If applicable:			)
Do use chemical tanning lotions?	NO	YES (Last time product was use	ed)
Do use a tanning bed? NO YES (#	#/Week/N	Month	,

**Family Medical History**: If you or a family member has EVER experienced any of the conditions listed below, please place the appropriate check mark and explain.

Condition	Self	Family	Please Explain
Lupus			
Hypothyroidism			
Skin Cancer			
Abnormal Moles			
Psoriasis / Eczema / Hives			
Herpes Simplex / Cold Sores			
Asthma			
COPD			
Pneumonia			
Atrial Fibrillation			
Murmur			
Angina (Chest Pain)			
Heart Attack			
Defibrillator / Pacemaker			
High Blood Pressure			
Gastric Reflux GERD / Bleeding			
Cancer (Any Type)			
Stroke / Seizures / TIA			
Diabetes (Type I or Type II)			
Anemia			
Any Conditions Not Listed Above?			

### **Female Patients Only:**

Date of Last Menstrual Cycle:	Are you pregnant?	Are you breastfeeding?		
	YES NO	YES NO		
Total Number of Pregnancies:	Total Number of Full-Term Pregnancies:	Menopause:		
		YES NO		

Do you currently have any of the following? If you check "YES" for anything, please explain on the line below.

NO	YES	
		CONSTITUTIONAL: Fevers, chills, recent unexplained loss of appetite or weight.
		<b>EYES</b> : Any recent unexplained change in visual acuity, double vision, excessive tearing or
		crusting?
		ENT: Any recent change in hearing ability, discharge, sore throat, nose bleeds, dizziness or
		ringing in the ears?
		CARDIAC: Any chest pain or discomfort, shortness of breath, waking from sleep,
		breathlessness, palpitations, cardiac medications?
	T	
		<b>RESPIRATORY</b> : Any shortness of breath, productive cough, coughing up blood, or pain when
		breathing?
	1	CACTROINTECTINAL. And showed in bould habite block on bloody stools viewsiting on storage
		<b>GASTROINTESTINAL</b> : Any change in bowl habits, black or bloody stools, vomiting or stomach pain?
		point.
		<b>GENITOURINARY</b> : Any incontinence, frequent, urgent or painful urination? Do you get up at
		night to urinate? If so, how often?
		, -
		MUSCULOSKELETAL: Any change in walking ability or strength? Painful joints?
	l	, , , , , , ,
		<b>SKIN</b> : Any problematic rashes or itching? Any changes in skin color or sores that will not heal?
		Any mole changes in size or color?
	•	
		NEUROLOGICAL: Any unexpected or unexplained numbness, tingling, or loss of memory or
		movement. Migraines or headaches?
		<b>PSYCHIATRIC:</b> Any depression, anxiety, suicidal thoughts, delusions or hallucinations?
		AIDS / HIV / HEPATITIS?
	I	T 11 2 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
		IV DRUG USE?
L		

#### **HIPAA ACKNOWLEDGEMENT:**

Occasionally it is necessary for Dr. Wright or a member of his staff to leave voice or text messages on your cell phone, answering machine, or possibly with a household member if they answer the phone. Generally, messages are left to notify you, the patient, that a member of our medical staff would like to discuss test results, scheduling an appointment, or to ask a patient to return our call regarding an issue or concern. You have the right to revoke this consent in writing at any time.

Do we have your permission to leave a message on phone num Do we have your permission to leave a message with a membe		n us? YES NO YES NO			
MEDICAL INFORMATION RELEASE					
I,, give per information (verbal or written) about me, my medical condition	mission for Dr. Wright and				
NAME (First and Last)	· · ·	IP TO PATIENT			
TANTE (TISE UND EUSE)	RELATIONS	III TOTATIENT			
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRA	ACTICES				
We are required by law to maintain the privacy of, and provide Privacy Practices with respect to Protected Health Information to speak with our HIPAA Compliance Officer in person or by ph	. If you have any objections				
Signature below is only acknowledgement that you have receive	ed this Notice of our Privac	cy Practices:			
Signature:	ignature: Date:				
PHOTOGRAPHY/VIDEOTAPING (FOR MEDIA OR EDUCATIONA	L PURPOSES)				
I hereby give my consent to have photographs, videotaped imate to interviews with a member of the news media or a represent and Vein Center. I understand and agree that these images materials of the purposes of transfer to the purpose	ative of Lakeview Medical ( ay be used by the media or	Group d/b/a Laser Lipo by Lakeview Medical			
Signature of Patient or Legal Representative Date	Witness	 Date			
<b>OFFICE USE ONLY:</b> Our practice will make a good faith effort to obtain a written A provided to the patient or the patients legal representative. If y practice must document its good faith efforts to obtain such ac acknowledgment was not obtained.	written acknowledgment is	not obtained, our			
Refused to Sign: Physically Unable to Sign:					
Other					
Employee Signature:	ate				

## **CANCELLATION / MISSED APPOINTMENT POLICY**

Thank you for choosing Laser Lipo and Vein Center. Our goal is to provide quality care in a timely manner to all patients. In order to do so, we have had to implement an appointment cancellation policy. This policy enables us to better utilize available appointments for patients in need of our care.

#### **Cancellation of an Appointment:**

We understand there are times when you must miss an appointment due to emergencies, obligations for work or family, and other unforeseen circumstances. In order to be respectful of the needs of other patients, please call Laser Lipo and Vein Center within 24 hours of your scheduled appointment time to reschedule your appointment. We understand there are times when 24 hours may not be possible; however, we would kindly ask that you notify us as soon as possible.

#### **Cancellation of Surgical Vein Appointments:**

If you need to cancel a surgical appointment, please notify our office within 48 hours. If there is an emergency or you become ill and are unable keep your appointment, please let us know as soon as possible.

#### **NO SHOW Policy:**

A "No-Show" is someone who misses an appointment without calling to cancel the appointment, or calls less than four (4) hours prior to their scheduled appointment time. In addition, if you arrive more than 15 minutes late for your appointment, we reserve the right to document the appointment as a "No-Show". Patients that arrive more than 15 minutes late for an appointment will be seen if the schedule allows. "No-Shows" inconvenience other patients. Failure to be present at the time of a scheduled appointment will be recorded in the patient's record as a "No-Show". All "No-Show" appointments will result in a fee of \$25.00, which will be billed to the patient's account. This fee is not covered by insurance. Patient's that have more than three (3) documented "No-Shows" in their record will be asked to call on the day they would like to be seen and will be accommodated only as the schedule allows.

#### **How to Cancel Your Appointment:**

To cancel an appointment, please call 636-397-4012 during regular business hours. If you are calling after hours, you may leave a detailed message on voicemail. You may also email or text your cancellation by responding to the automated appointment confirmation message or by emailing <a href="mailto:dawn@wrightvein.org">dawn@wrightvein.org</a>. If you would like to reschedule your appointment, please leave your phone number and the best time to return your call. You may also reschedule via email.

Signature of Patient	 Date	
LLVC Employee	 Date	