# CARDIOVASCULAR & THORACIC SURGERY, P.C.

***Vein Management Clinic – Laser Aesthetic Center***

Issa E. Muasher, M.D.
950 N. York Road, Suite 104 – Hinsdale, IL 60521

## REGISTRATION/RELEASE FORM

**PLEASE PRINT**

Patient name: _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: (  ) _____ Cell Phone: (  ) _____
EMAIL: _____
Date of Birth: _____ Marital Status: S M W D Social Security #: _____

Primary/Referring Physician: _____
First Name Last Name
Physician Phone Number: _____

Retired? Y N Employed? Y N Occupation: _____
Employer: _____ Phone #: (  ) _____
Street Address: _____
City: _____ State: _____ Zip Code: _____

**Emergency Contact:**
Name: _____ Relation: _____
Phone #: (  ) _____ Cell #: (  ) _____

PRIMARY INSURANCE: _____
SECONDARY INSURANCE: _____

I authorize Cardiovascular & Thoracic Surgery, P.C. / Vein Management Clinic / Laser Aesthetic Center / Issa E. Muasher, M.D. to release to my insurance carrier(s) information and/or to provide copies of my medical/billing records (excluding mental health treatment, alcoholism treatment, drug abuse treatment, HIV/Acquired Immune Deficiency Syndrome records) for the purpose of obtaining payment for services rendered. I also authorize my insurance carrier(s) to make payment for these services to Cardiovascular & Thoracic Surgery, P.C. / Vein Management Clinic / Laser Aesthetic Center / Issa E. Muasher, M.D. or their billing agent when assignment is accepted. I have completed this form fully and completely and certify that I am the patient/guardian or an authorized general agent of the patient authorized to furnish this information.

I understand that even though I may have insurance coverage, I am responsible for payment of these services. I understand that if I am covered by an HMO policy I am responsible for ensuring a referral has been authorized and received prior to receiving services. If no authorization is provided I will be responsible for payment in full. Payment is due at time of service for co-pay and self-pay services not covered by insurance. **Should we need to bill you any outstanding balances are due IN FULL within 30 days of the statement date.** Unless payment arrangements are made in advance DIRECTLY WITH OUR OFFICE all balances that reach 90 days will be subject to collection procedures. I understand that if my account is turned over to a collection agency all collection/legal costs for recovery will be added to my balance for which I am responsible for payment.

Signature of Patient or Responsible Party: _____

**Date:** _____ _____
Relationship if other than patient

*I hereby authorize Cardiovascular & Thoracic Surgery, P.C. / Vein Management Clinic / Laser Aesthetic Center / Issa E. Muasher, M.D. to release any information regarding my diagnosis and treatment to the following:*

_____ *Relation:* _____

# REQUEST FOR CONFIDENTIAL COMMUNICATION

I, _____ Hereby request Issa E. Muasher, M.D. Cardiovascular & Thoracic Surgery, P.C. to keep communications regarding my protected health information (PHI) confidential. To accomplish this request, please adhere to the following requests.

**PHONE** You can contact me by phone at

Home # _____

Work # _____

Cell # _____

Other # _____

Leave message on answering machine _____ Yes _____ No

Leave message with any other person _____ Yes _____ No

Comments _____

**Mail:** Contact me at the following address _____

_____

**Billing:** Direct billing correspondence to:

_____

_____

**Other requests for confidential communications:** _____

_____

Signed: _____ Date: _____

# PATIENT MEDICAL HISTORY

*Cardiovascular & Thoracic Surgery, P.C. – Vein Management Clinic*

Issa E. Muasher, M.D.

Name: _____ Date: _____

Date of Birth: _____ Age_____ Height: _____ Weight: _____

Primary/Referring Physician: _____

**ALLERGIES:** **Yes** ___ **No** ___ **If Yes**, please list medication(s) and type of reaction(s):_____

_____

_____

_____

**MEDICATIONS:** Please list current name, dose and frequency (including over-the-counter) _____

_____

_____

_____

**PAST SURGERIES/OTHER MEDICAL CONDITIONS:** _____

_____

_____

_____

**FAMILY/SELF HISTORY:** Do you or your family have history of:

| | Self | Family | | Self | Family |
|---|---|---|---|---|---|
| Coronary Artery Disease: | | | Vein or Artery Disease: | | |
| High Blood Pressure: | | | Stroke: | | |
| Heart Disease: | | | Cancer: | | |
| Lung Disease: | | | Tuberculosis: | | |
| Kidney Disease: | | | Depression: | | |
| Liver Disease: | | | Neurological: | | |
| Gastrointestinal Disease: | | | Migraines: | | |
| Diabetes: | | | Other: | | |

**SOCIAL HISTORY:**

Use of Tobacco: Yes ☐ _____Pack(s) per day Quit ☐ _____months/years ago Never ☐

Use of Alcohol: Daily ☐ _____ Socially ☐ _____ Never ☐

Use of Drugs: In the past ☐ Never ☐

**WOMEN ONLY:** ***(Please check box if yes)***

- ❑ Are you pregnant or considering a pregnancy sometime in the future?
- ❑ Are you breast-feeding?
- ❑ Are your legs more painful associated with menstruation?
- ❑ Have you been diagnosed with Pelvic Congestion Syndrome?
- ❑ Do you currently take oral contraceptives?
- ❑ Are you on hormone replacement therapy?
- ❑ Did your veins develop before, during or after a pregnancy? _____

  Number of pregnancies? _____ Number of deliveries? _____

**NAME:**_____

Reason you are seeking treatment for your veins: **Medical**____ **Cosmetic**____

How long have you had this condition before seeking treatment? _____

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?**

| Please check which apply: | Yes | No | Left | Right |
|---|---|---|---|---|
| Unsightly, bulging veins | ☐ | ☐ | ☐ | ☐ |
| Aching / pain in the legs | ☐ | ☐ | ☐ | ☐ |
| Heaviness | ☐ | ☐ | ☐ | ☐ |
| Tiredness / fatigue / restless | ☐ | ☐ | ☐ | ☐ |
| Itching / burning | ☐ | ☐ | ☐ | ☐ |
| Swelling / edema | ☐ | ☐ | ☐ | ☐ |
| Throbbing | ☐ | ☐ | ☐ | ☐ |
| Pigmentation (discoloration) | ☐ | ☐ | ☐ | ☐ |
| Dermatitis (eczema) | ☐ | ☐ | ☐ | ☐ |
| Ulceration | ☐ | ☐ | ☐ | ☐ |
| Night cramps | ☐ | ☐ | ☐ | ☐ |
| Leg Trauma / surgery | ☐ | ☐ | ☐ | ☐ |
| Prior evaluation of your legs | ☐ | ☐ | ☐ | ☐ |
| Bleeding from a vein | ☐ | ☐ | ☐ | ☐ |
| Deep vein thrombosis (clot) | ☐ | ☐ | ☐ | ☐ |
| Superficial vein thrombosis | ☐ | ☐ | ☐ | ☐ |
| Phlebitis (inflammation of a vein) | ☐ | ☐ | ☐ | ☐ |
| Any type of clotting disorder | ☐ | ☐ | ☐ | ☐ |
| Are your veins getting worse? | ☐ | ☐ | | |
| Does prolonged sitting or standing aggravate your veins? | ☐ | ☐ | | |
| Do your symptoms interfere with your sleep? | ☐ | ☐ | | |
| Do your symptoms interfere with walking / daily activity? | ☐ | ☐ | | |
| Were you ever treated with blood thinners? | ☐ | ☐ | | |
| Have you ever taken steroids? | ☐ | ☐ | | |
| If yes, when _____ for how long? _____ | | | | |
| Have you had treatment by: Vein stripping or EVLT | ☐ | ☐ | ☐ | ☐ _____ |
| Sclerotherapy (injections) | ☐ | ☐ | ☐ | ☐ _____ |
| Is there a family history of vein disease, ulceration or clots? | ☐ | ☐ | | |

If yes, please list relatives who are affected: _____

Conservative Treatment Used Previously and/or Currently: (***Please check treatments that you have tried)***

Pain medications ☐ Herbal supplements ☐ Leg elevation ☐ Exercise ☐ Weight loss ☐

Compression stockings ☐ If so, for how long ?_____

**PATIENT SIGNATURE**: _____