MILNER
VEIN & VASCULAR

Dr. Timothy Milner MD Andrea Holley PA-C Kyle O'Donnell PA-C

Phone Number: (678) 580-1149 Fax Number: (770) 557-1347

Lithonia
5700 Hillandale Dr.
Ste 120
Lithonia GA 30058

Conyers
1775 Parker Rd SE
Building C Suite 24
Conyers, GA 30094

Tucker
4500 Hugh Howell Rd
Ste 310
Tucker, GA 30084

Snellville
2366 Lenora Church Rd
Snellville, GA 30078

PATIENT REGISTRATION FORM

DATE: _____

PATIENT NAME: _____SS#: _____

DATE OF BIRTH: _____/_____/_____ SEX: M / F (CIRCLE ONE) MARRIED / SINGLE / D / W

HOME ADDRESS: _____

CITY: _____STATE: _____ZIP CODE: _____

E-MAIL ADDRESS: _____

CELL PHONE#: _____WORK PHONE#: _____

EMPLOYER'S NAME: _____PHONE#: _____

EMPLOYER'S ADDRESS: _____CITY: _____STATE: _____ZIP CODE_____

PHARMACY NAME: _____CITY: _____PHARMAC TEL#: _____

PRIMARY CARE MD: _____ PHONE#: _____

How did you hear of our practice? _____

Person responsible for the bill? Self or Other: _____ Insured or Self-Pay

Guarantor Name: _____SS#: _____

Employer's Name: _____Phone: _____

INSURANCE: _____POLICY: _____

EMERGENCY CONTACT: _____PHONE#: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP CODE: _____

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PATIENT CONSENT FORM

CONSENT FOR ROUTINE PROCEDURES & TREATMENTS
We are required by law to obtain a consent to treat and disclose "all material risks and alternative treatments."
I understand that it is not possible to list every material risk for every Procedure and Treatment and this form only attempts to identify the most common material risks and the alternative associated with the Procedure and Treatment.

The Procedures may include, but not limited to the following:

1) Needle Sticks, such as injections (shots), intravenous lines, or intravenous injections. The material risks associated with these types of Procedures include, but not limited to nerve damage, infections, infiltrations (which is fluid leakage into the surrounding tissue), disfiguring scar, loss of limb function, paralysis, or partial paralysis of limb or even death. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
2) Physical tests, assessment, and treatments such as vital signs, internal body examinations, wound cleaning, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but not limited to allergic reactions, infections, serve loss of blood, muscular skeletal or internal injuries, nerve damage, loss of limb function, paralysis, partial paralysis, disfiguring scar, worsening of the condition and death, apart from using modified Procedures and/or refusal of treatment, no practical alternative exist.
3) Administration of Medications whether orally, rectally, topically or through the eye, ear, or nose. The material risks associated with these types of Procedures include, but not limited to perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.
4) Drawing Blood, Bodily Fluids, or Tissue Samples such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but not limited to paralysis, patrial paralysis, nerve damage, infection, bleeding, and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

By signing this form:

- I consent to healthcare professionals performing procedure as they deem reasonably necessary in the exercise of their professional judgement, including these procedures that may be unforeseen or not known to be needed at the time this consent is obtained; and
- I acknowledge that I have been informed in general terms of the nature and purpose of the procedures, the material risks of the procedures and practical alternatives to the procedures.
- If I have any questions or concerns regarding these treatments or Procedures, I will ask my physicians to provide me with additional information.
- In order to ensure medication safety and lack of drug interactions, I grant Emory Healthcare and its staff the right to access my electronic pharmacy and prescription information.

Signature of Patient (or authorized person to sign):_____
Print Name of Patient:_____
Reason Patient unable to sign(if applicable):_____
Date:_____

Patient approval form for physician assistant: If this has a certified Mid-Level Provider available to treat patients for the level of care, which of have been approved by the Georgia State Board of Medical Examiners, your signature on this form conveys that you agree with being treated by a Mid-Level provider, who is acting under the direct supervision of a physician.

_____ _____
Signature Date

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CANCELLATION AND NO-SHOW POLICIES

For Doctor Appointments and Procedures

Patients must call **24 hours in advance** to cancel or reschedule an appointment. Failing to do so will result in a **$25 fee** after two missed appointments. This will not be covered by your insurance company.

Due to the large block times needed for procedures, last minute cancellations can cause problems and become an added expense for the office. If your procedure is not cancelled at least **2 days in advance**, the patient will be charged a **$75 fee**. This charge will not be covered by your insurance.

Billing and Account Balances

This office requires that self-pay patients have the responsibility of settling all charges prior to receiving further services by our practice. Patients who have questions regarding their bills are encouraged to speak with the administrative staff. This office is open to setting up a formal payment plan with our billing specialist. Patient will balance over $100 must make payment arrangements prior to future appointments being made.

_____

Print Patient's Name

_____ _____

Signature Date

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HIPAA stands for **Health Insurance Portability and Accountability Act**. This federal law has brought many changes to the healthcare industry, specifically in the areas such as:

- Protecting and ensuring the privacy of the patient's health information
- Regulation to protect electronic health information
- Standards for transmitting electronic data.

As your provider, we are committed to maintaining the privacy of your information, as well as communicating with you in the most effective manner. Please take a moment to complete this form to ensure that we can contact you.

I authorize the MILNER VEIN & VASCULAR to contact me regarding my medical information by means of the listed methods below. I will also be responsible for contacting this office should this information change.

Home telephone#: _____

May we leave messages on your home answering machine? Yes No

Work telephone#: _____

May we leave messages on your work voice mail? Yes No

Cell telephone#: _____

May we leave messages on your work voice mail? Yes No

The providers/staff may use or disclose the following health information only to the following list of people.

- All test Results YES NO
- The entire medical record YES NO
- Today's Chart notes YES NO
- Any healthcare provider or facility YES NO
- Spouse YES NO Name: _____
- Parent(s) YES NO Name: _____
- Children YES NO Name: _____
- Other: Please give name and relationship (i.e., aunt, uncle, cousin, etc.)
- Name:_____
- Relationship: _____

Patient/ Parent/ Guardian signature:_____

Date:_____

Acknowledgement of receipt of notices of privacy practices (HIPPA Policies): I acknowledge that I have received the notice of privacy policies.

_____ _____

SIGNATURE DATE

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DATE:_____

Please send REQUESTED Medical Records TO:

Milner Vein & Vascular

Phone Number 678-580-1149 Fax Number 770-557-1347

MEDICAL RECORDS REQUEST FORM

Patient's Name:_____DOB:_____

Phone#:_____ SS#:_____

Home address:_____

City:_____ State:_____ Zip Code:_____

E-mail Address:_____

AUTHORIZATION Release of my Medical Records To:

Physician Name:_____ Office Phone#:_____

Office Address:_____

City:_____ State:_____ Zip Code:_____

AUTHORIZATION Request of my Medical Records From:

Physician Name:_____Office#:_____

Office Address:_____

City:_____ State:_____ Zip Code:_____

Patient's Signature:_____

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Date:_____

Name:_____

DOB:_____/_____/_____

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

- Do you experience leg pain, cramping or aching when you are walking?
  YES____ NO____
- Do you experience pain in your legs at night?
  YES____ NO____
- Do you have open wounds or sore s on your legs?
  YES____ NO____
- Have you ever had a procedure done on your veins or arteries? (EXAMPLES: venous ablation, stent placement, or vascular bypass, etc.)
  YES____ NO____
- Have you ever worn or currently wear compression garments?
  YES____ NO____
- Have you experienced or currently experiencing any tingling, numbness, or achiness in your lower extremities?
  YES____ NO____
- Do you have any tiredness or coldness in your feet?
  YES____ NO____

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PATIENT MEDICAL HISTORY

DATE:_____

NAME:_____AGE:_____DOB:____/____/_____

PRIMARY CARE PHYSICIAN:_____REFERRING PHYSICIAN:_____

REASON FOR TODAYS VISIT:_____

BP:_____/_____HT:_____WT:_____PULSE:_____RESP:_____

CURRENT MEDICATIONS			
NAME of MEDICATION	Dosage(mg)	INSTRUCTIONS (how many---how often)	Start Date

PREFERRED PHARMACY: _____TELEPHONE:_____

ADRRESS:_____

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DATE: _____

NAME:_____

TELEPHONE#:_____

SOCIAL HISTORY

Do you use tobacco?	YES___	NO___
Former smoker?	YES___	NO___, when did you stop smoking DATE:_____
Do you drink alcohol?	YES___	NO___, how often? _____drinks per day.
On dialysis?	YES___	NO___, on what days: M, W, F or T, Th, S

Allergies: (Medications, contrast, dyes, latex, foods, other substances)

PAST MEDICAL HISTORY(blood clots, cancer, CAD, diabetes, high cholesterol, hypertension, kidney disease, stroke, TIAs, cardiac arrhythmia disease liver disease, gall bladder, HIV, etc.)

Types of Medical Diseases	Date the disease was diagnosed	Primary medication being taken

PAST SURGICAL HISTORY: hospitalizations, arterial or venous procedures, bypass grafts, AAA repair,

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AVF/AVG (what side), BKA/AKA (what side)-peripheral vascular disease or diabetes?)

Type of Surgical Disease	Date of Hospitalization/Operation	Type of Post-surgical Care

FAMILY HISTORY/GENETIC CONDITIONS: sickle cell disease or Trait, Thalassemia diseases, Carotid artery obstruction, migraine headache, Marfan Syndrome, Cancer, Hypertensive disease, diabetes mellites, smoking history, vascular disease-self, siblings, parents, grandparents?

Name of Disease	Genetic or Acquired Conditions	Self, siblings, parents, grandparents

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Patient History and Review of System

General

☐ Fever
☐ Chills
☐ Fatigue/Weakness
☐ Peripheral Edema
☐ Malaise
☐ Weight Loss

Endocrine

☐ Diabetes-Insulin Dependent
☐ Diabetes-Non-Insulin Dependent
☐ Hyperthyroid
☐ Hypothyroid

Musculoskeletal

☐ Stiffness
☐ Restless Legs
☐ Arthritis
☐ Low Back Pain
☐ Back Pain
☐ Joint Pain
☐ Joint Swelling
☐ Muscle Cramps
☐ Muscle Weakness

Respiratory

☐ Smoking
☐ Cough
☐ Coughing up Blood
☐ Shortness of Breath
☐ Pulmonary Embolism
☐ On home Oxygen

Cardiovascular

☐ CHF
☐ Chest Pain
☐ Heart Attack
☐ Palpitations
☐ Heart Murmur
☐ Fainting
☐ Hypertension
☐ PTCA
☐ CABG

Hematology/Oncology

☐ Coumadin/Blood Thinners
☐ Cancer
☐ History of Blood Clots
☐ Positive for HIV

Neurological/Psychological

☐ Mental Status
☐ Frequent Falls
☐ Poor Balance
☐ TIA's
☐ Stroke
☐ Headaches
☐ Paralysis
☐ Numbness or Tingling
☐ Seizures
☐ Tremors

Gastrointestinal

☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Indigestion/Heartburn
☐ Constipation
☐ Change in Bowel Habits
☐ Abdominal Pain
☐ Dark, Tarry Stool
☐ Bloody Stools

Vascular

☐ History DVT/Blood Clot
☐ AV Graft
☐ IVC Filter
☐ Aneurysm
☐ Varicose Veins
☐ Pain in Legs
☐ Swelling in Leg
☐ Leg/Foot Ulcers
☐ Leg/Foot Gangrene
☐ Pain with Walking
☐ Pain at Rest
☐ Previous Bypass
☐ Carotid Stenosis

Other Symptoms:

_____

_____

_____

_____