1428 MAIN STREET - SUITE 2
WALPOLE, MASSACHUSETTS 02081
TELEPHONE (508) 660-1115
FAX (508) 660-1114

JOHN T. FRASCA, M.D.

GENERAL & VASCULAR SURGERY

Please PRINT CLEARLY **Today's Date:** _____

Patient's Full Name: _____ DOB: _____ AGE: _____

Marital Status: (Circle) S M D W Sep. Sex: (Circle) F or M SS#: _____

Primary Address: _____ Primary Phone #: _____

Town: _____ ST: _____ ZIP: _____ Secondary Phone #: _____

Secondary Address: _____ Phone #: _____

Town: _____ Dates/Time of Year Residing at the secondary address:

E-Mail Address: _____ _____

Employer Name: _____ Work Phone #: _____

Primary Care Physician: _____ PCP Phone #: _____

PCP Address: _____ Town: _____ ST: ____ ZIP: _____

Referring Physician: _____ Phone #: _____

Address: _____ Town: _____ ST: ____ ZIP: _____

Spouse Name: _____ Primary Phone #: _____

Spouse Address: _____ Town: _____ ST: ____ ZIP: _____

****

Emergency Contact Name: _____ Relationship: _____

Address: _____ Town: _____ ST: ____ ZIP: _____

Primary Phone #: _____ Secondary Phone #: _____

****

MEDICATION ALLERGIES

Are you allergic to ANY medication? (Circle) NO YES Are you allergic to X-Ray Contrast? (Circle) NO YES

Have you ever had a reaction to anesthesia? (Circle) NO YES

If yes, please list below.

Name of Medication Allergy	Type of Reaction

NON-MEDICATION ALLERGIES **Type of Reaction**

Breathing Dust NO YES, Smoke NO YES _____

Fumes NO YES, Animals NO YES _____

Iodine, Soaps or Shellfish NO YES _____

Latex NO YES _____

Tape or Adhesive NO YES _____

Other _____ NO YES _____

(REV 2/13)

Patient Name: _____ **Today's Date:** _____ (rev. 2/13)

Health Insurance Information

[PRIMARY]

Insurance Company Name: _____ Policy ID#: _____

Address: _____ Group #: _____

City: _____ ST: ____ Zip: _____ Subscriber Name: _____

Insurance Co Phone #: _____ Subscriber DOB: _____

Type of insurance: (CIRCLE) HMO PPO OTHER: _____

Do you have a Copayment for Physician office visits: (Circle) NO YES Amount of Copayment per visit: _____

[SECONDARY]

Insurance Company Name: _____ Policy ID#: _____

Address: _____ Group #: _____

City: _____ ST: ____ Zip: _____ Subscriber Name: _____

Insurance Co Phone #: _____ Subscriber DOB: _____

Type of insurance: (CIRCLE) HMO PPO OTHER: _____

Do you have a Copayment for Physician office visits: (Circle) NO YES Amount of Copayment per visit: _____

INJURIES AND ACCIDENTS (If Applicable) Please circle one:

Were you injured at Work? NO YES In an Auto Accident? NO YES Personal Injury? NO YES

Date of Injury/Accident: _____ Claim #: _____

Name of Insurance Company: _____ Ins. Co Phone #: _____

Ins Co Address: _____ City: _____ ST: ____ ZIP: _____

Is there an attorney involved? (Circle) NO YES

Attorney's Name: _____ Attorney Phone #: _____

Atty. Address: _____ City: _____ ST: ____ ZIP: _____

Complete this section if someone other than the patient is legally or financially responsible for the patient:

Responsible Party Name: _____ Relationship to Patient: _____

Address: _____ Town: _____ ST: ____ ZIP: _____

Primary Phone#: _____ DOB: _____ Soc Sec #: _____

Secondary Phone #: _____

Employer: _____ Phone #: _____

ALL HMO'S AND SOME PRIVATE INSURANCE CARRIERS REQUIRE PRIOR AUTHORIZATION (REFERRALS) FOR EACH OFFICE VISIT. *THIS IS THE PATIENT'S RESPONSIBILITY TO OBTAIN*. IF THE OFFICE OF JOHN T. FRASCA, M.D. DOES NOT RECEIVE THE AUTHORIZATION PRIOR TO THE VISIT, I UNDERSTAND THAT PAYMENT FOR THE VISIT WILL BE THE PATIENT'S (GUARDIAN OR PARENT, IF APPLICABLE) RESPONSIBILITY.

I HEREBY CONSENT TO TREATMENT, AND AUTHORIZE THAT PAYMENT BE MADE DIRECTLY TO JOHN T. FRASCA, M.D. FOR SERVICES PROVIDED TO ME IN THE COURSE OF MY MEDICAL CARE. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. IF ANY COLLECTION ACTIVITIES ARE COMMENCED REGARDING MY UNPAID BALANCE, I AGREE TO BE RESPONSIBLE FOR ALL COSTS AND ATTORNEY FEES ASSOCIATED THEREWITH. I FURTHER UNDERSTAND THAT 1/5% PER MONTH INTEREST WILL BE ACCRUED ON ANY OUTSTANDING BALANCES OVER 60 DAYS.

Patient/Guardian Signature: _____ DATE: _____

Patient Name: _____ **Today's Date:** _____

SMOKING

Are you a current smoker: (circle) YES or NO
If yes, how much do you currently smoke: _____ **Cigarettes Cigars Other (circle)**
If no, have you ever smoked: (circle) YES or NO
If yes, how long ago did you quit smoking: _____ **How much did you smoke:** _____

MEDICATIONS

Are you taking ANY kind of medications now? (Circle) NO YES
NOTE: This includes prescription, over-the-counter and/or herbal medications.

Please note that it is the **patient's (or guardian's) responsibility** to update us each and every time these medications change to ensure that the patient will receive appropriate on-going care.

LIST OF MEDICATION- ***PLEASE PRINT LEGIBLY***

MEDICATION	DOSE	FREQUENCY EACH DAY	MD NAME PRESCRIBED	REASON FOR PRESCRIPTION

Patient/Guardian Signature: _____ **Date:** _____

*****Please update this form at least annually for your personal safety. It is your responsibility to notify our office of all medication changes.**

*****Please bring the completed form to your scheduled appointment with Dr. Frasca.**

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JOHN T. FRASCA, M.D.

GENERAL & VASCULAR SURGERY

Authorizations

I have received a copy of the Notice of Privacy Practices from the office of John T. Frasca, M.D. and understand that I have patient rights under the law of the Health Information Portability and Accounting Act (HIPAA).

Patient or Parent/Guardian Name: _____
Patient or Parent/Guardian Signature: _____
Date:_____

I hereby authorize Dr. Frasca to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and there, authorize payment of the insurance benefits directly to him for any services rendered that are not paid for directly by me.

I hereby authorize Dr. Frasca to obtain any and all information from my other healthcare providers concerning diagnosis and treatment for the purpose of and as it pertains to my treatment while under his care.

Patient or Parent/Guardian Name: _____
Patient or Parent/Guardian Signature: _____
Date: _____

My signature authorizes the office of John T. Frasca, M.D.

To leave messages regarding appointments/procedures on my-

Home answering device:	Yes ____	No ____
Office answering device:	Yes ____	No ____
Cell phone answering device:	Yes ____	No ____
Fax Machine:	Yes ____	No ____

Other (please describe- i.e. spouse numbers) _____

To send correspondence regarding appointment/procedures to my home:
Yes ____ No ____

Patient or Parent/Guardian Name: _____
Patient or Parent/Guardian Signature: _____
Date: _____

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GENERAL & VASCULAR SURGERY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office inform you of your rights to privacy of medical information and how this office may appropriately disclose such information to others.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for the following purposes only:

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. Example: discussion of your medical situation between your primary care physician and a specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing and collecting activities or utilization reviews. Example: sending a bill for your visit to your insurance company for payment.
- Health Care Operations includes sharing your medical information with others for certain routine business purposes. Example: internal quality care review.

We also may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights regarding your personal medical information:

- The right to request in writing that all or portions of your personal medical information be restricted from family members, other individuals, insurance carriers and other entities.
- The right to request confidential communication of your personal medical information by reasonably practical means.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.
- The right to file a written complaint with our office, the Department of Health & Human Services or the Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office without retaliation. For more information about HIPAA or to file a complaint you may contact:

The U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619-0257
Toll Free: 1-877-695-6775

We are required to provide you with this notice. We are required by law to make all reasonable efforts to respect and maintain the privacy of your personal medical records. This notice is effective April 1, 2008. We reserve the right to change the terms of our *Notice of Privacy Practices* currently in effect and make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised *Notice of Privacy Practices* from this office. (Rev. 1/2012)

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GENERAL & VASCULAR SURGERY

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Patient Name: _____ **Today's Date:** _____

DOB: _____ Home Phone: _____ Cell Phone: _____
(MM/DD/YYYY)

We appreciate your time very much. We are now required by Federal Standards to collect the following information.

Pharmacy Name: _____

Pharmacy Address: _____ Town: _____ ST: _____

Email Address (If you do not have one please state "None"):

_____

Sex:

- ☐ Male
- ☐ Female
- ☐ Transgender

Race (Check One):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Island
- ☐ Black or African American
- ☐ White
- ☐ Unspecified
- ☐ Some Other Race
- ☐ Decline to State

Ethnicity (Check One:

- ☐ Unspecified
- ☐ Declined to State
- ☐ Hispanic or Latino
- ☐ Non Hispanic or Latino

Preferred Language:

- ☐ English
- ☐ Indian (Includes Hindi & Tamil)
- ☐ Other
- ☐ Russian
- ☐ Spanish

VEIN SCREENING FORM
Please complete left side of form only.

Date: _____ Appt Time: _____ Screening Provider: _____

Name: _____ Primary Care Physician: _____

DOB: _____ Sex: ☐M ☐F Insurance Provider: _____

Daytime phone number: _____ How did you hear about the screening? _____

I. Vascular History

Do you have or have you ever been diagnosed with:

Varicose vein problems	☐Y ☐N	Leg: ☐R ☐L
Phlebitis (vein redness/tenderness)	☐Y ☐N	Leg: ☐R ☐L
Blood clots	☐Y ☐N	Leg: ☐R ☐L
Deep vein thrombosis (DVT)	☐Y ☐N	Leg: ☐R ☐L
Saphenous vein reflux	☐Y ☐N	Leg: ☐R ☐L

Do you experience any of the following in your leg(s):

Aching/pain	☐Y ☐N	Leg: ☐R ☐L
Heaviness	☐Y ☐N	Leg: ☐R ☐L
Tiredness/fatigue	☐Y ☐N	Leg: ☐R ☐L
Itching/burning	☐Y ☐N	Leg: ☐R ☐L
Swelling	☐Y ☐N	Leg: ☐R ☐L
Cramps	☐Y ☐N	Leg: ☐R ☐L
Restless legs	☐Y ☐N	Leg: ☐R ☐L
Throbbing	☐Y ☐N	Leg: ☐R ☐L
Skin or ulcer problems	☐Y ☐N	Leg: ☐R ☐L
Other:	☐Y ☐N	Leg: ☐R ☐L

Which of the following do you currently do to improve your leg vein symptoms:

Medication for pain	☐Y ☐N	What? _____
Elevation of legs	☐Y ☐N	What? _____
Wear support hose	☐Y ☐N	What? _____

II. Family History

Have any of your family members had:

Varicose veins	☐Y ☐N	Who? _____
Vein stripping	☐Y ☐N	Who? _____
Blood coagulation disorder	☐Y ☐N	Who? _____
Blood clots	☐Y ☐N	Who? _____
Stroke, heart attacks or pulmonary emboli	☐Y ☐N	Who? _____

III. Vein Treatment History

Have you ever been treated for varicose veins with:

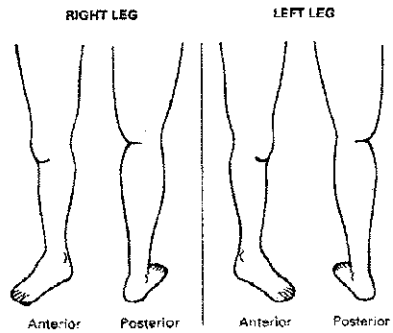
Sclerotherapy	☐Y ☐N	Leg: ☐R ☐L
Laser therapy (spider veins)	☐Y ☐N	Leg: ☐R ☐L
Phlebectomy	☐Y ☐N	Leg: ☐R ☐L
Vein stripping surgery	☐Y ☐N	Leg: ☐R ☐L
RF ablation (VNUS Closure®)	☐Y ☐N	Leg: ☐R ☐L

IV. Personal Activities List

Does your work require:

Prolonged standing periods	☐Y ☐N	
Prolonged sitting periods	☐Y ☐N	
Do you exercise regularly?	☐Y ☐N	
Do you smoke?	☐Y ☐N	
Pregnancies	☐Y ☐N	How many? ___

V. Vein Screening (to be completed by screening provider)



Physical Exam:

CEAP Clinical Signs:

RIGHT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

LEFT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

Clinical Assessment:

☐ Chronic venous insufficiency ☐R ☐L
☐ Other: _____ ☐R ☐L

Treatment Plan:

☐ Duplex ultrasound ☐R ☐L
☐ Sclerotherapy ☐R ☐L
☐ Medical compression stockings ☐R ☐L
☐ Other: _____ ☐R ☐L

Screening Provider Signature: _____

Follow-Up Appointment

Date: _____ Time: _____

Physician: _____

Physician Phone Number: _____

NOTES: