Lakeview Medical Group
Laser Lipo and Vein Center
Thomas Wright, MD FACP RVT

New Patient Registration:

Patient Name:	Last Name	First Name	Middle Initial
Social Security Number: (*Medical Appointments Only)*		Date of Birth:	Sex: M / F *(Please Circle One)*
Marital Status: S M D W *(Please Circle One)*	Race *(Optional):*	Ethnicity (*Optional*):	
Street Address:			
City:		State:	Zip:
Primary Phone Home / Cell / Work *(Please Circle One)*		Secondary Phone Home / Cell / Work *(Please Circle One)*	
Email: (Required for Insurance and HIPPA Portal – Not shared other entities)		Email Appointment Confirmations YES NO *(Please Circle One)*	
Would you like to receive our newsletter? YES NO *(Please Circle One)*		Text Appointment Confirmations YES NO *(Please Circle One)*	

Employment Information:

Employer Name:		Occupation:	
Employer Address:		Employer Phone:	
City:		State:	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 Number:		Relationship:	

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Insurance Information:

Primary Insurance Information		Secondary Insurance Information	
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 have? (*Please Circle)* HMO / POS / PPO		What type of plan do you have? (*Please Circle)* HMO / POS / PPO	
If you need a referral, it is your responsibility as the patient to obtain a referral from your primary care physician. *Please bring your referral paperwork to your first appointment, or have it faxed to our office (636-278-1670)*			

Assignment of Benefits / Release of Information

I authorize my health insurance benefit plan to pay directly to Lakeview Medical Group d/b/a Laser Lipo and Vein Center, medical benefits made either to me or on my behalf to Dr. Thomas F. Wright for any services furnished to me. I authorize any holder of medical or other health information about me to release to my health insurance provider or their agents any information needed to determine these benefits or benefits for related services. I understand that I am financially responsible for any charges not covered by my insurance provider. Further, I authorize Lakeview Medical Group d/b/a Laser Lipo and Vein Center to release any and all information necessary, including medical records and personal health information to secure payment.

_____ _____

Signature of Responsible Party Date

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Medical Information:

Primary Care Physician:	Phone Number:
Pharmacy:	Phone Number:

Are you currently being treated for any medical conditions? YES NO

If yes, who is the treating physician and what are you being treated for:	Physician:
Condition:	

Medications – List all medications you are taking including vitamins and herbal remedies:

Medication	Dosage	How Often Do You Take This Medication?

List All Allergies:

Medications	Other Allergies

List All Surgeries and Dates:

Surgery	Date / Year (Approx.)

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Social Habits:

Do you drink alcoholic beverages? NO YES (#/Week _____)

Do you now, or have you ever used tobacco? NO YES (Packs/Week _____)

Quit Date (If applicable: _____)

Do use chemical tanning lotions? NO YES (Last time product was used _____)

Do use a tanning bed? NO YES (#/Week/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? YES NO	Are you breastfeeding? YES NO

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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.
		EYES: 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?
		RESPIRATORY: Any shortness of breath, productive cough, coughing up blood, or pain when breathing?
		GASTROINTESTINAL: Any change in bowl habits, black or bloody stools, vomiting or stomach pain?
		GENITOURINARY: 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?
		SKIN: 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?
		PSYCHIATRIC: Any depression, anxiety, suicidal thoughts, delusions or hallucinations?
		AIDS / HIV / HEPATITIS?
		IV DRUG USE?

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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 number(s) you have shared with us? **YES NO**
Do we have your permission to leave a message with a member of your household? **YES NO**

MEDICAL INFORMATION RELEASE

I, _____, give permission for Dr. Wright and staff to release information (verbal or written) about me, my medical condition, and/or treatment to the following person(s).

NAME (*First and Last*)	**RELATIONSHIP TO PATIENT**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this Notice of our Legal Duties and Privacy Practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 636-397-4012.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature: _____ Date: _____

PHOTOGRAPHY/VIDEOTAPING (FOR MEDIA OR EDUCATIONAL PURPOSES)

I hereby give my consent to have photographs, videotaped images, or other images made of myself and/or consent to interviews with a member of the news media or a representative of Lakeview Medical Group d/b/a Laser Lipo and Vein Center. I understand and agree that these images may be used by the media or by Lakeview Medical Group d/b/a Laser Lipo and Vein Center for the purposes of training, advertising, and/or marketing.

_____ _____ _____ _____
Signature of Patient or Legal Representative Date Witness Date

OFFICE USE ONLY:

Our practice will make a good faith effort to obtain a written Acknowledgement of Receipt of the Notice of Privacy provided to the patient or the patients legal representative. If written acknowledgment is not obtained, our practice must document its good faith efforts to obtain such acknowledgment and record the reason why the acknowledgment was not obtained.

Refused to Sign: _____ Physically Unable to Sign: _____

Other _____

_____

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Employee Signature: _____Date_____

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 dawn@wrightvein.org. 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*