**Patient Name:** ___________________________________________ **Gender:** □ Male □ Female

**Date of Birth:** ______________________ **Social Security Number:** _________________________

**Address:** _______________________________ **City:** ________________________ **Zip:** ________

**Home Phone:** ___________________ **Cell:** __________________ **Work:** ___________________

**Marital Status:** □ Single □ Married □ Separated □ Divorced □ Widow

**Race:**
□ American Indian or Alaska Native □ Asian □ Black or African American
□ Hispanic or Latino □ Native Hawaiian or Other Pacific Islander □ White
□ Decline to Specify

**Preferred Language:** □ English □ Spanish □ Polish □ Italian **Other:** ____________

**Emergency Contact: Name / Phone Number:** ___________________________________________

**Access to patient portal:** □ **Yes** □ No **(selecting yes will enable you to access your medical summary notes)**

**Email address:** __________________________

**Occupation:** ____________________________ **Employer:** ______________________________

**Business Address:** _______________________________________________________________

**Patient Signature:** ______________________________________**Date:** ______________________

# Health History Form

Patient Name: ____________________________________Date of Birth: ______________________

Name of Primary Care Physician:____________________________________________________

Address:_______________________________________________________________________________
Phone: ______________________________ Fax: ______________________________________________

Why are you here today? Where and what type of improvement is desired rom laser hair removal?

_______________________________________________________________________________________

_______________________________________________________________________________________

How did you hear about NJ Vein Care?_____________________________________________________

Are you on any medications either prescribed or over the counter? List Below ☐ Yes ☐ No

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Do you have any allergies to medication? ☐ Yes ☐ No
If yes, please list drug and reaction

_______________________________________________________________________________________

Do you smoke tobacco? ☐ Yes ☐ No ☐ Quit Packs per day for how many years?____________________

Do you consume alcohol? ☐ Yes ☐ No ☐ Quit Drinks per week?__________________________________

Other drugs?___________________________

Have you had any past surgical procedures? ☐ Yes ☐ No
If yes, please list type and date

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Have you had any past hospitalizations? ☐ Yes ☐ No
If yes, please list reason and date

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Do you have any of the following conditions? (Please check all that apply and describe below)

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ☐ | Diabetes | ☐ | Kidney Disease | ☐ | Chest Pain | ☐ | Arthritis | ☐ | Heat Urticaria (Hives) |
| ☐ | Heart Disease | ☐ | Hepatitis | ☐ | Shortness of Breath | ☐ | High Blood Pressure | ☐ | Blood Disorders |
| ☐ | Lung Disease | ☐ | Blood Clots | ☐ | Leg Pain | ☐ | Varicose Veins | ☐ | Skin Photosensitivity |
| ☐ | Stroke | ☐ | Bleeding Problems | ☐ | Swelling of Legs | ☐ | Leg Ulcers | ☐ | Autoimmune Disorders/Immunosuppression |
| ☐ | Stomach Ulcers | ☐ | High Cholesterol | ☐ | Spider Veins | ☐ | Cancer | ☐ | Bacterial or viral infections |

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Do you have any other medical conditions or illness not listed? ______________________________________

___________________________________________________________________________

Family History. (Check all that apply)

| | | Father | Mother | Sibling | Other |
|---|---|---|---|---|---|
| ☐ | Blood Clots | ☐ | ☐ | ☐ | ☐ |
| ☐ | Bleeding Problems | ☐ | ☐ | ☐ | ☐ |
| ☐ | Leg Ulcers | ☐ | ☐ | ☐ | ☐ |
| ☐ | Varicose Veins | ☐ | ☐ | ☐ | ☐ |
| ☐ | Heart Disease | ☐ | ☐ | ☐ | ☐ |
| ☐ | Stroke | ☐ | ☐ | ☐ | ☐ |
| ☐ | High Blood Pressure | ☐ | ☐ | ☐ | ☐ |
| ☐ | High Cholesterol | ☐ | ☐ | ☐ | ☐ |

Is there any other medical information that you would like to share?

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

# Hair Removal History Form

Patient Name: ____________________________________Date of Birth: ______________________

| Question | | |
|---|---|---|
| (For women) are you or could you be pregnant? | Yes | No |
| | | |
| (For women) are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder? | Yes | No |
| | | |
| Do you have a history of light induced seizures? | Yes | No |
| If yes, please explain: | | |
| | | |
| Do you have or have you ever had any type of a skin disorders, such as eczema, vitiligo, melisma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos Syndrome, scleroderma, skin cancer: or any other skin condition? | Yes | No |
| If yes, please explain: | | |
| | | |
| Do you have a history of keloid scarring (extra-large scars) or hypertrophic scar formation? | Yes | No |
| | | |
| Do you have a history of herpes I or II? | Yes | No |
| | | |
| Do you ever get cold sores, skin eruptions, open sores or lesions? | Yes | No |
| | | |
| In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory medications? | Yes | No |
| If yes, please list name of product and when last used: | | |
| | | |
| In the last three (3) months, have you used any of the following products: glycolic acid or other alpha hydroxy or beta hydroxy acid products: exfoliating or resurfacing products or treatments? Such as dermabrasion or a chemical peel? | Yes | No |
| If yes, please list name of product; and when used: | | |
| | | |
| Have you taken Tretinoin (like Retin-A, Renova) in the last 6 months? | Yes | No |
| If yes, when did you start? When did you stop? | | |
| | | |
| Have you taken Accutaine (or products containing isotretinoin) in the last 12 months? | Yes | No |
| If yes, when did you start? When did you stop? | | |
| ` | | |
| Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? | Yes | No |
| If yes, when did you start? When did you stop? | | |
| | | |
| Do you have or have you ever had any Botulinums, such as Botox or Dysport? | Yes | No |
| If yes, please list locations on or in the body and dates: | | |
| | | |
| Do you have or have you ever had any permanent make-up, tattoos, implants or fillers, including, but not limited to, collagen, autologous fat, Restylane, etc? | Yes | No |
| If yes, please list locations and dates? | | |
| | | |
| Have you had any type of treatment for unwanted facial/body hair in the past? | Yes | No |
| If yes; What type? When did you start? When did you stop? | | |
| | | |
| Have you had any complications with cosmetic treatments or surgery in the past? | Yes | No |
| If yes; What type? What complication? | | |
| | | |
| | | |

# SKIN TYPING WORKSHEET

Patient Name: ___________________________________Date of Birth: _____________________

| **Score:** | | **0** | **1** | **2** | **3** | **4** |
|---|---|---|---|---|---|---|
| | What is your eye color? | Light blue or Gray | Blue or Green | Hazel, Light brown | Dark brown | Brownish black |
| | What is the natural color of your hair? | Red, Sandy red | Blonde | Dark blonde, Chestnut, Brown | Dark brown | Black |
| | What is the color of your skin (unexposed areas)? | Reddish | Very pale | Pale with beige tint | Light brown | Dark brown |
| | Do you have freckles on sun-exposed areas? | Many | Several | Few | Incidental | None |
| | What happens when you stay in the sun too long? | Painful redness, blistering, peeling | Blistering, followed by peeling | Burns, sometimes followed by peeling | Rarely burns | Never had burns |
| | To what degree do you turn brown? | Hardly any or not at all | Light tan | Reasonable tan | Tan very easily | Turn dark brown quickly |
| | Do you turn brown several hours after sun exposure? | Never | Seldom | Sometimes | Often | Always |
| | How does your face respond to the sun? | Very sensitive | Sensitive | Normal | Very resistant | Never had a problem |
| | When did you last expose yourself to the sun, tanning be or self-tanning creams? | More than 3 months ago | 2-3 months ago | 1-2 months ago | Less than 1 month ago | Less than 2 weeks ago |
| | How often is the area you want to have treated exposed to the sun? | Never | Hardly ever | Sometimes | Often | Always |

| Add above for Total Score: | Match your total score with the corresponding Skin Type: | Fitzpatrick Skin Type: |
|---|---|---|
| | 0-7 | I |
| | 8-16 | II |
| | 17-25 | III |
| ____________ | 26-30 | IV |
| | Over 30 | V-VI |

# LOCATION OF EXCESS HAIR

Patient Name: ______________________________________Date of Birth: _______________________

(Please circle all that apply)

| | | | | |
|---|---|---|---|---|
| Sideburns | Chest | Neck | Areola | Eyebrows |
| Shoulders | Gluteal | Back | Underarm | Full Face |
| Nose | Arms | Abdomen | Ears | Bikini |
| Lip | Chin | Hands | Feet | Legs |
| Flanks | Sacrum | Beard | | |

***I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the Doctor and staff of NJ VeinCare of my current medical/health conditions and to update this history as needed. I understand that a current medical history is essential for the Doctor to execute appropriate treatment procedures.***
***I understand that laser hair removal is not immediately permanent and that a series of treatments is necessary to achieve permanent hair reduction. I understand the success of treatments depends largely on my cooperation with my treatment schedule and recommendations by the laser technician. I agree to inform the technician of any changes in my skin after treatment, as well as changes in my general health.***

Patient Signature: _________________________________________________________ Date: ______________________

Doctor Signature: _______________________________________________________ Date: _____________________

1037 US Highway 46 E. Suite 202 • Clifton, NJ 07013 • Phone: (973) 778-2222 • Fax: (973) 860-1148
Website: www.njveincare.com

**Our Practice Financial Policy**

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our office administrator.

**Full payment is due at the time of service for cosmetic procedures**. For your convenience we will accept cash, check, or credit card for payment.

**We also participate with Care Credit that can be used to finance both cosmetic and non-cosmetic procedures including deductibles and co-insurance.**

We are **not in network** with Medicaid or Managed Medicaid plans.
We are **not in network** with BCBS Advance EPO
We are **not in network** with Americhoice or Amerigroup

We are "in network" with Medicare, Horizon Blue Cross/Blue Shield of NJ, Aetna, United Health Care, Oxford, Magnacare, Amerihealth, Care Point, OSCAR, Qualcare and Cigna. **Patients are responsible for knowing if referrals are needed and obtaining referrals prior to an appointment at NJ VeinCare.**

If you have other medical insurance with "out of network benefits", we will work with you to obtain coverage for procedures performed due to medical necessity. We do accept "out of network benefits".

If in the event your health plan ultimately determines a service to be "not covered" or does not meet their criteria for medical necessity, you would be responsible for the complete charge.

Prior to any scheduled procedure we will provide patients with the CPT codes. **It is your responsibility to check with your insurance company to determine what your out of pocket costs will be.** Payment is due upon receipt of the Explanation of Benefits from your insurance company. It lists what you owe NJ Vein Care. **If payment to NJ VeinCare is not received within 60 days, interest at a rate of 1.5% per month will accrue. After 90 days, unless other arrangements have been made, your account will be sent to a collections agency.** This would result in an additional charge from the collections agency and/or legal fees over what you owe to NJ VeinCare.

A fee of $30.00 will be charged on any checks returned by the bank for insufficient funds.

**Patients will be charged a fee of $50.00 if they fail to cancel an appointment 1 day in advance. If a patient fails to give 1-day advance notice of cancellation for a cosmetic procedure, any discount that was given for the procedure may be forfeit.**

**I have read and understand the financial policy of NJ Vein Care and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.**

Print Name of Patient ________________________________________________________

Signature of Patient or Guardian________________________________ Date _____________

## ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign, transfer, and set over directly to NJ VeinCare, LLC sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic or elsewhere. I authorize Gary B. Nackman, MD /NJ VeinCare, LLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Gary B. Nackman, MD /NJ VeinCare, LLC. I authorize Gary B. Nackman, MD /NJ VeinCare, LLC to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

Print Name of Patient ________________________________________________________

Signature of Patient or Guardian________________________________ Date _____________

## PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). I understand that by signing this consent I authorize you to use and disclosure my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operation of your practice.

I have also been informed of and give the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Name of Patient ____________________________________________________________

Signature of Patient or Guardian__________________________________ Date _____________

**You have the right:**

- To considerate and respectful care consistent with sound nursing and medical practices
- To be informed of the name of the physician responsible for coordinating your care
- To obtain from the physician complete, current information concerning your diagnosis, treatment, and prognosis in terms I can reasonably be expected to understand
- To receive from the physician information necessary to give informed consent prior to the start of any procedure or treatment
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such action; You can still obtain alternative care.
- To privacy to the extent consistent with providing adequate medical care to you
- To privacy and confidentiality of all records pertaining to the your treatment, except as otherwise provided by law or third party payment contract, and to access to those records
- To review your medical records and if necessary have them explained to you
- To know what alternative care may be available to you
- To know what your treatment may cost

**You have the responsibility:**

- To provide all information about your past care, illness and medication to your physician
- To for being considerate to the needs of others in the office
- To provide all insurance information when requested, and following the requirements for your individual insurance plan for seeking treatment with the Doctor

Print Name of Patient ______________________________________________________

Signature of Patient or Guardian__________________________________ Date _____________