

8120 S. Holly St., Suite 111

Centennial, CO 80122

Phone: 303-741-4060

Fax: 720-242-7666

**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Registration -**

Patient Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of work do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: (M) (D) (S) (W) Sex (M) (F)

**How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

**Primary Insurance**

Insurance Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID/Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employers Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**

Insurance Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Dr. David Siroospour to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all the charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency.

Signature of Patient/ Authorized Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I authorize the physician to release any information required in the process of this claim and all future claims.**

Signature of Patient/ Authorized Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**

**Medical History**

Please check any Diseases/Conditions YOU have had:

\_\_\_\_\_Anemia

\_\_\_\_\_Cancer - Type \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Leukemia

\_\_\_\_\_Diabetes

\_\_\_\_\_Thyroid – Type \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Glaucoma

\_\_\_\_\_Lung Disease

\_\_\_\_\_Tuberculosis

\_\_\_\_\_Heart Attack/Angina

\_\_\_\_\_Ulcers

\_\_\_\_\_High Blood Pressure

\_\_\_\_\_Other Heart Disease

\_\_\_\_\_Colitis

\_\_\_\_\_Liver Disease

\_\_\_\_\_Gallbladder Trouble

\_\_\_\_\_Kidney Stone/Disease

\_\_\_\_\_Gout

\_\_\_\_\_Epilepsy/Seizures

\_\_\_\_\_ High Cholesterol

\_\_\_\_\_Asthma

\_\_\_\_\_Headaches

\_\_\_\_\_Enlarged Lymph Nodes

\_\_\_\_\_Swollen Ankles

\_\_\_\_\_ Other Please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies to Medications: (Please list any allergies to medications)**

(List Here) 🡪\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or, **No Known Drug Allergies**

(Circle all that apply)

**Allergic to Latex?**  YES / NO

**Do You Smoke?** YES / NO / FORMER SMOKER How many cigarettes/packs a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

**Do You Drink Alcohol?** YES / NO How many drinks a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Height**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family History of: (circle all that apply)**

Mother: Varicose Veins / Spider Veins / Leg Ulcers / Swollen legs

Father: Varicose Veins / Spider Veins / Leg Ulcers / Swollen legs

Sister: Varicose Veins / Spider Veins / Leg Ulcers / Swollen legs

Brother: Varicose Veins / Spider Veins / Leg Ulcers / Swollen legs

Grand Parents: Varicose Veins / Spider Veins / Leg Ulcers / Swollen legs

**Current Medications. Please list medication and why you take it:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: For \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: For \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: For \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: For \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_

**Venous Medical History**

**(Please Circle One)** What is the reason you are seeking treatment for your veins: ( Medical ) or ( Cosmetic )

How long have you had the veins you are concerned about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your veins develop during a pregnancy? **YES / NO**

Does prolonged sitting or standing aggravate your veins? **YES / NO**

Have you ever had treatment for your veins? If so, which leg and what type of treatment?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do your legs ever **(Please check all that apply)**:

**No Symptoms**\_\_\_\_ **Swell**\_\_\_ **Ache**\_\_\_\_ **Feel Tired** \_\_\_\_ **Feel Heavy**\_\_\_ **Pain**\_\_\_\_

**Have Bulging Veins**\_\_\_\_ **Leg Cramps** \_\_\_\_ **Restless Leg Syndrome (RLS)** \_\_\_\_ **Itching** \_\_\_\_ **Burning**\_\_\_\_

Have you ever been treated for a blood clot in your legs? If yes, when and which leg?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or have you ever worn compression hose? **YES / NO.** If yes, for how long and did it help?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have history of Phlebitis? **YES / NO.** Which Leg? **LEFT / RIGHT**

Do you have history of Spontaneous Bleeding? **YES / NO.** Which Leg? **LEFT / RIGHT**

**(Please circle which one)** Do you take **Tylenol / Ibuprofen / Advil / Aleve** to help your symptoms? **YES / NO.**

**If yes, how often and does it help with your symptoms? YES / NO.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you elevate your legs? **YES / NO.** Does it relieve your symptoms? **YES / NO.**

Does walking relieve your symptoms? **YES / NO.** Does walking make your symptoms worse? **YES / NO.**

Do you exercise? **YES / NO** If yes, what kind and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How do your symptoms interfere with your daily activities?**

\_\_\_\_ They prevent me from traveling long distances by car

\_\_\_\_ They cause me to lose sleep at night

\_\_\_\_ They prevent me from being more active

\_\_\_\_ They prevent me from doing certain duties at my job

\_\_\_\_ They do interfere with my daily activities

**Patient Payment Responsibility Acknowledgment**

(**Insurance patients**)

Please know that we are happy to submit insurance claims to your insurance company as a courtesy to you.  
Be advised that with the overwhelming number of insurance policies and contracts we must rely on you to know your insurance policy; this includes network inclusions or exclusions, co-payment amounts, deductibles, and limitations. If you have any questions regarding your insurance coverage please call them directly to enquire.  
  
Co-payments **will** be collected same day as your scheduled appointment. This requirement is stated in all insurance company contracts.

(**Non-Insurance patients**)

Please know that any services performed must be paid by the individual patient or other party. We accept: cash, credit card, or check payments.

Thank You.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT OF HIPPA POLICIES**

You have the right to request restrictions on the way we use your medical information. You have the right to request and receive information from us in a different way or manner. You have the right to review your medical information. You have the right to know how we have used and to whom we have disclosed your medical information. We will not use or disclose your health information without your permission except as otherwise described in this notice of privacy practice and policy.

It is our responsibility to protect your medical information, provide you with our notice of privacy policies and abide by these policies. We do reserve the right to change our privacy practices.

I acknowledge receipt of the Notice of Privacy Practices for Colorado Laser and Vein, PC.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT OF APPOINTMENT POLICIES**

**No show Policy**

Not showing up for your scheduled appointment, will result in you being charged $50 for each Aesthetic or Office appointment you were booked or $100 for each procedure you were booked.

Initial: \_\_\_\_\_\_\_

**Late Policy**

Please make every effort to be on time. Your appointment will not be held for more than 15 minutes. We have to be considerate of other patient’s appointments as well as the doctor’s schedule.

Initial: \_\_\_\_\_\_\_

**Appointment Cancellation Policy**

Please be considerate and respectful of other clients and our staff by contacting us at least 24 hours before your scheduled appointment time if you wish to cancel. Cancellations within 24 hours will result in you being charged $50 for each Aesthetic or Office appointment you were booked or $100 for each procedure you were booked.

Initial: \_\_\_\_\_\_

**I CERTIFY THAT I HAVE READ, FULLY UNDERSTAND THE ABOVE PARAGRAPHS AND THAT I HAVE HAD SUFFICIENT OPPORTUNITY TO ASK ANY QUESTIONS.**

PLEASE SIGN BELOW

PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



David Siroospour, MD, FACS

PHOTO CONSENT AND RELEASE FORM

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I consent for photographs and/or video images to be taken of me by Colorado Laser and Vein, Inc. or a representative. I understand the images will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media). By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me. I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images: (please initial indicating YES or NO below)

\_\_\_\_\_\_\_\_ YES \_\_\_\_\_\_\_\_ NO For educational purposes (medical teaching or training), \_\_\_\_\_\_\_\_ YES \_\_\_\_\_\_\_\_ NO For marketing and advertising purposes (website, print, digital, or social media), \_\_\_\_\_\_\_\_ YES \_\_\_\_\_\_\_\_ NO At my request, my photographs and/or video images will only be used as part of my medical record.

I hereby release Colorado Laser and Vein, Inc., its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation. By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via written request submitted to Colorado Laser and Vein, Inc. or by completion of a new form.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_