JEAN W. GILLON M.D.
2900 WHIPPLE AVE. SUITE # 200
REDWOOD CITY, CA 94062
PHONE (650) 364-3828 FAX (650)361-1727

Registration Form

The confidential information requested below will be used only to enhance the accuracy of your medical evaluation.

Referred by_____

Today's Date:_____

Patient Information:

Last Name:_____First Name:_____

Date of Birth:_____/_____/_____Age:_____Social Security#:_____

Sex: Female Male Marital Status: Single Married Divorced Widowed Separated

Spouse's/ Significant Other's Name:_____

Home Address:_____

City:_____State:_____Zip:_____

Mailing Address if different from address listed above:

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email Address:_____

Employer:_____Occupation:_____

Emergency Contact Name:_____Phone Number:_____

Pharmacy Name:_____Phone Number:_____

Insurance Information:

Primary Insurance:_____Secondary Insurance:_____

Named of Insured_____Date of Birth:_____/_____/____

Relationship to patient:_____Social Security#:_____

The reason you are here:_____

What are your main complaints?_____

How Long?_____Tests done? (Ultrasound, CT, etc)_____

Do you or have you ever had any of the following:

Heart Problems (Heart Attack, Pacemaker, Valve problems, Chest pain):_____

High Blood Pressure:_____

Breathing Problems (Emphysema, Asthma, Shortness of breath):_____

Diabetes:_____

Kidney Problems:_____

Hepatitis or Jaundice:_____

Seizures, Migraines, Stroke, Weakness:_____

Depression, Anxiety Attacks, Psychiatric Conditions:_____

Bleeding or Clotting Problems:_____

Substance Problems:_____

Autoimmune Disorders:_____

Cancer:_____

Major Surgeries:_____

Please list your medications:_____

Allergies:_____

Have you ever received a Blood Transfusion?_____

Have you ever had problems with General Anesthesia?_____

Number of Pregnancies, when?_____

Smoking History:_____Alcohol Usage:_____

I authorize my insurance company to pay directly to Jean W. Gillon, M.D. all benefits to which I am entitled for the services provided by Dr. Jean Gillon and to the release of any information to secure the payment.

I understand that the responsibility for payment of all fees is mine regardless of insurer allowance or disallowance.

Signature:_____Date:_____

If there are unexpected financial problems, we are willing to set up a payment plan to help you.

Questionnaire for Patients with Venous Problems

Do you have or have you ever			Circle one		# of Years
Varicose vein problems:	□ Yes	□ No	Right Leg	Left Leg	_
Phlebitis (redness, tenderness of a	□ Yes	□ No	Right Leg	Left Leg	_
Deep Vein Thrombosis (DVT):	□ Yes	□ No	Right Leg	Left Leg	_
Pulmonary Embolism:	□ Yes	□ No	Right Leg	Left Leg	

Do any family members have varicose veins? _____

Do you have a history of blood clotting or coagulation disorders? _____

Do you experience any of the following in your legs, if so please indicate where:

Resting pain:	□ Yes	□ No	Where:
Resting cramps:	□ Yes	□ No	Where:
Night cramps:	□ Yes	□ No	Where:
Tiredness:	□ Yes	□ No	Where:
Heaviness in the legs:	□ Yes	□ No	Where:
Numbness:	□ Yes	□ No	Where:
Burning sensation:	□ Yes	□ No	Where:
Itching:	□ Yes	□ No	Where:

Is the pain made worse by any of the following: (Please check all that apply)

□ Extended periods of standing □ Walking and/or Exercising □ Menstrual periods

□ Heat □ Medication □ Elevation of the limbs

Is the pain improved by any of the following?

Elevation of the limbs	□ Yes	□ No
Compression Stockings	□ Yes	□ No
Walking and /or	□ Yes	□ No

Have you ever been treated for varicose veins with any of the following: (Please check all that apply)

□ Sclerotherapy (Injections) □ Laser treatment for spider veins

□ Closure (Endovenous Radiofrequency Ablation) □ Endovenous Laser Ablation

□ Vein Stripping □ Other Surgery:_____

Office Notice of Privacy Practices

Dr. Jean W. Gillon

This notice describes how your health information may be used and disclosed and how you can access its information. Please review it carefully.

At The Office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may disclose your health information for our normal healthcare operations. For example, your information may be entered into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may save this information on your answering machine or with the person who answers the telephone. In an emergency we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If the practice is sold, you information will become property of the new owner. Except as described above, the practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information describe above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. We will mail your files for you for a fee. You have the right to see and receive a copy of your health information. Give us written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies. You have the right to request an amendment or change to your health information. Give us our request to make changes in writing. If you wish to include a statement in your files, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your files. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information. You have the right to receive a copy of this notice. You may file a complaint with the *Department of Health and Human Services, 200 Independence Ave. S.W. Room 509F, Washington, DC 20201*. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health privacy, please contact our Privacy Officer, Dolores Centis (650)364-3828. This notice goes into effect as of April 14, 2003.

Acknowledgement: I received a copy of The Office Notice of Privacy Practices.

Signature:_____Date:_____