Brandt J. Feuerstein, M.D., FACS

General Surgery **Phone: (302) 735-8850**
Fax: (302) 735-8851

Thank you for choosing our practice. We are located at Eden Hill Medical Center Suite 300, Dover, DE. Dr. Feuerstein is a General Surgeon that also has an added specialty of varicose veins and venous insufficiency. Our practice name is The Vein Center at Eden Hill.

This is a patient information packet for you to fill out and bring in at the time of your visit. If information is not completed prior to your appointment, your appointment may be rescheduled. Please bring your insurance cards and a current picture ID. *This packet goes out to new patients and to established patients every year as required by your Insurance Company*.

If you need a referral or authorization, please contact your primary care physician. ***If we do not have a referral before your appointment time, your appointment will be rescheduled.***

Your insurance contract is an agreement between you and the insurance company, and as the subscriber, you are responsible for the terms of that agreement. ***Therefore, your copay is due at the time of your visit***. We accept payment by cash, check, credit cards. We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

Please contact our office at your earliest convenience if you have any questions or concerns. ***Please be aware that if you are late to your appointment, it may be necessary to reschedule it to another day.***

Our office uses a Reminder service for appointments. The service will email, text, and call. You will get all three if you don't confirm the appointment. New patients are required to arrive 15 mins prior to appointment time. There is a $40.00 missed appointment fee if not rescheduled or cancelled 48 hours prior.

Our office also uses a Patient Portal so that you will always have access to your information. This will be given to you at the office. It is not for emergency use. If you don't want to use this service, you can always shred the information given to you.

At this time Face Mask are optional, if you're not feeling well it is advised to reschedule the appointment.*

When you arrive, your temperature will be taken by one of our staff using a thermometer. If your temperature is 99.5 degrees F or above, we will be unable to see you that day and ask that you reschedule. In the last 14-21 days, if you are experiencing any cough, fever shortness of breath or difficulty breathing, any flu-like symptoms, such as gastrointestinal upset, headache, fatigue, recent loss of taste and/or smell, been diagnosed with COVD-19 or Traveled internationally? If Yes we will need to reschedule the appointment.

*** For the safety of our patients and staff, only the patient and one other person is permitted. We ask if possible not to bring children to the office.

The Vein Center at Eden Hill
200 Banning St, Ste 300
Dover, DE 19904
Phone (302)735-8850
Fax (302) 735-8851

PATIENT INFORMATION (Please Print)

Name (Last, First, MI) ______ Social Security ______ DOB ______ Age ______ Marital Status ______

Home/Mailing Address ______ City ______ State ______ Zip Code ______

Primary Phone ______ Secondary Phone ______ Tertiary Phone ______ Gender ______ Race/Ethnicity ______ Language ______

Reminder Preferences Check all that apply: Phone Only ☐ Email ☐ Text Message ☐

Email:______

RESPONSIBLE PARTY

Name (Last, First, MI) ______ Social Security ______ Birth date ______ Sex ______ Home Phone ______

Address ______ City ______ State ______ Zip Code ______ Marital Status ______

Family Doctor______Office Phone ______ Fax______

Referring Provider______Office Phone______ Fax______

INSURANCE INFORMATION

Primary Insurance ______ Subscriber's Name, DOB, SSN ______ Relationship ______ Policy# ______ Group# ______ Copay ______

Secondary Insurance ______ Subscriber's Name, DOB, SSN ______ Relationship ______ Policy# ______ Group# ______ Copay ______

I authorize The Vein Center at Eden Hill to contact in case of Emergency. I authorize The Vein Center at Eden Hill to discuss my medical records with the following people. (HIPAA) Please list HIPAA contact/s if None for HIPAA then list None after Emergency Contact.

Names: ______ Phone: ______ Relationship: ______ HIPAA Y / N | EC

Names:______ Phone: ______ Relationship: ______ HIPAA Y / N | EC

Names:______ Phone: ______ Relationship: ______ HIPAA Y / N | EC

My signature below indicates that I authorize The Vein Center at Eden Hill to call my home or cell phone and leave a message, either with a person or on an answering machine if they need to contact me for any reason:
OK to call ______ NOT OK to call______

AUTHORIZATION FOR TREATMENT, PAYMENT AND OPERATIONS
I give consent for treatment of care by The Vein Center at Eden Hill. I authorize them to release any information for my treatment to the parties necessary. I also assign directly all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, including procedures and surgeries. I also authorize the doctor to release necessary information for laboratory or insurance company follow-up as stated in the posted Privacy Policy Notice. I am aware I can receive a copy of the notice upon request (please specify below). I authorize the use of this signature on all insurance submissions.
__Yes, I would like a copy of the Privacy Policy Notice; ___No, thank you.

SIGNATURE: ______ DATE: ______REV 04/27/23

THE VEIN CENTER AT EDEN HILL PATIENT MEDICAL HISTORY FORM

Name:____ DOB:____________ Date:____________

Referring Physician:__________________________Cardiologist:_________________________

Primary Care Physician:_______________________PainManagement:____________________

Other:____

REASON FOR VISIT (CIRCLE/FILL IN BLANK):

What Symptoms?______________________________

____

Do you have pain: Y / N

Describe the pain:

Achy/ burning/ dull/ sharp/ stabbing

Other:_____________________________________

How severe is the pain?

Mild/ moderate/ severe/ incapacitating

Location of the pain?___________________________

Does the pain radiate? Y / N

If yes, what location?

____

How long have you had this problem?

Days/ weeks/ months/ years

What makes the problem better?_________________

____

Have you taken any medication to help the problem?

Tylenol/ Advil/narcotic pain pill __________________

What makes the problem worse?_________________

____

Do you have any other symptoms? (circle)

Fever/ chills/ night sweats/ decreased appetite/ nausea/ vomiting/ weight loss/ weight gain/ constipation/ diarrhea/blood in stool/ cramps or pain/ painful BMs/black stools abdominal bloating

ANY HISTORY OF INFECTIONS?

Do you or does anyone in your family/household have a history of any of the following?

MRSA ☐ yes ☐ no

VRE ☐ yes ☐ no

C. DIFF ☐ yes ☐ no

WORK HISTORY:

Retired / Employed/ Unemployed/ Disabled

Job title: ______________________________________

What type of work did you do/or do?

____

SOCIAL HISTORY:

Tobacco Use? Yes or No Vaping or E Cigarette?

Start Year :______ Quit Year:___________

Former Smokers How many years did you smoke: _____

Current Smokers How many packs per day:__________

In the last thirty days? __________

Risk for Second Hand Smoke? ☐ Yes ☐ No

Smokeless Tobacco: ☐ Yes ☐ No Last 30 days? ___

Do you use alcohol? ☐ Yes ☐ No

Daily: ☐ Weekly: ☐ beer/ wine/ liquor

Substance abuse: Never/ current/ former

Narcotic abuse: Never/ current/ former

Caffeine use: Coffee/ tea/ energy drinks

Dietary Supplements:__________________________

____

Continued on Back

FEMALE PAST HISTORY: (CIRCLE)

PATIENTS NAME:_______________________________

Are you pregnant? Y / N

# of pregnancies:________________________________

# of children:___________________________________

Your age at 1st pregnancy:________________________

Oral contraceptive use? Y / N (# of Years____________)

Hormone replacement? Y / N (# of Years____________)

Hysterectomy: Y / N

Date of last menstrual period:_____________________

Age at first menstrual period:______________________

Where do you get your mammograms?_____________

Date of last mammogram?________________________

FAMILY HISTORY: (CIRCLE)

Father: None / unknown/ Heart Disease/ Lung Disease

Diabetes/ Breast Disease/ Thyroid Disease

Cancer(Type):___________________________________

Mother: None / unknown/ Heart Disease/ Lung Disease

Diabetes/ Breast Disease/ Thyroid Disease

Cancer(Type):___________________________________

Brother: None / unknown/ Heart Disease/ Lung Disease

Diabetes/ Breast Disease/ Thyroid Disease

Cancer(Type):___________________________________

Sister: None / unknown/ Heart Disease/ Lung Disease

Diabetes/ Breast Disease/ Thyroid Disease

Cancer(Type):___________________________________

DOB:____

RECENT TESTING:

Were you seen in the ER: If so where and when:

____

Have you had any studies done or are any studies scheduled, if so what type, where and when?

____

PATIENT NAME:________________________________ DOB:_____________________

MEDICAL PROBLEMS: (PLEASE CHECK ALL PROBLEMS YOU ARE BEING TREATED FOR)

☐ Angina	☐ Dizziness/ Fainting	☐ Low Blood Pressure
☐ Arthritis	☐ Emphysema	☐ Mitral Valve Prolapse
☐ Asthma	☐ Eye trouble	☐ Rectal Disease
☐ Bladder Problems	☐ Gallstones	☐ Seizures
☐ Bleeding Disorder_______________	☐ GERD	☐ Sexually Trans Diseases
☐ Blood Clots	☐ Headache	☐ Shortness of Breath
☐ Cancer_______________________	☐ Heart Attack	☐ Stomach/Ulcer
_______________________________	☐ Heart Murmur	☐ Stroke/ TIA
☐ Chest Pain	☐ Hemorrhoids	☐ Thyroid
☐ Cirrhosis	☐ Hepatitis	☐ Tuberculosis
☐ COPD	☐ High Blood Pressure	☐ Varicose Veins
☐ Depression	☐ Kidney Problems / ☐ Chronic ☐ Dialysis	☐ Diabetes Type I / II

PAST SURGICAL HISTORY:

Year of Last Colonoscopy:_________Surgeon:_________________ Year of Last Mammogram:_________________________

Do you have an Advance Directive? __________________________

ALLERGIES: Are you allergic to any of the following? Iodine/ Fish/ eggs/ IVP dye

Medication Allergy	Allergic Reaction*	Severity
1.		
2.		

*(options: unsure, **mild reactions**: rash, hive, itching, nausea, vomiting; **severe reactions**: fever, throat swelling, anaphylaxis)

PHARMACY	PHONE	ADDRESS

MEDICATIONS: (Please include medication name and dosage information. You can provide list for us to copy)

1.______________________________ 2.______________________________ 3.______________________________

4.______________________________ 5.______________________________ 6.______________________________

Prior Surgical History/ Doctor	Date	Surgical History/ Doctor	Date
1.		4.	
2.		5.	
3.		6.	

CONTINUED ON BACK

PATIENT NAME:______________________________ DOB:____________________

ANY PAST SURGERY CONCERNS:

Have you had any problems with anesthesia?

Airway problem / breathing / heart / nausea/ vomiting

Is there a family history of either? (CIRCLE)

Malignant hyperthermia or

Pseudocholinesterase deficiency

IMPLANTED DEVICES: (CIRCLE)

Port / Pacemaker/ AICD / Spinal Cord Stimulator/

Pain Pump or Insulin Pump

PROSTHETIC JOINTS: (CIRCLE)

Do you have any of the following: Y / N

Knee: R / L/ Both

Hip: R / L/ Both

Other:_______________________________________

DO YOU TAKE BLOOD THINNERS? (CIRCLE)

Do you take any of the following: Y / N

Aspirin / Coumadin / Plavix / Aggrenox / Pradaxa

Other:_______________________________________

PROSTHETIC HEART VALVE? (CIRCLE)

Do you have a Prosthetic Heart Valve? Y / N

Aortic / Mitral

Metal/ Porcine/ Bovine

Do you take antibiotics before procedures? Y / N

If yes, what antibiotic?________________________