

Rockland Thoracic and Vascular Associates PC

Patient Information Sheet

Date _____

Name, Last _____ First _____ MI _____ M/F _____

Age _____ Date of Birth ____-____-____

Address _____ City _____ State _____ Zip _____

Phone-Home _____ Cell _____ Work _____

Social Security # _____-_____-_____ Spouse/Guardian _____

Emergency Contact _____ Phone _____

Employer _____

Employer's Address _____ City _____ State _____ Zip _____

Ethnicity/Race Check all that apply

____ American Indian/Alaska Native ____ Native Hawaiian/Other Pacific Islander

____ Asian ____ White

____ Black/African American ____ No Response

____ Hispanic/Latino/Spanish Origin

Preferred Language

____ English ____ Spanish ____ French ____ Other _____

Insurance-Primary _____

Policy # _____ Group # _____

Cardholder's Name _____ Date of Birth ____-____-____

Relationship to Patient _____

Insurance-Secondary _____

Policy # _____ Group # _____

Cardholder's Name _____ Date of Birth ____-____-____

Relationship to Patient _____

Rockland Thoracic and Vascular Associates PC

Name _____

Date _____

Please list all physicians involved in your care:

Physician _____ Specialty _____

Address _____ City _____ State _____ Zip _____

Phone Number (____) _____ - _____

Physician _____ Specialty _____

Address _____ City _____ State _____ Zip _____

Phone Number (____) _____ - _____

Physician _____ Specialty _____

Address _____ City _____ State _____ Zip _____

Phone Number (____) _____ - _____

Physician _____ Specialty _____

Address _____ City _____ State _____ Zip _____

Phone Number (____) _____ - _____

Physician _____ Specialty _____

Address _____ City _____ State _____ Zip _____

Phone Number (____) _____ - _____

Rockland Thoracic and Vascular Associates PC

Name _____

Date _____

MEDICAL HISTORY

The information concerning my medications and medical history is true and correct to the best of my belief.

Patient's Initials **X** _____

STATEMENT OF FINANCIAL RESPONSIBILITY

All professional services rendered by Rockland Thoracic and Vascular Associates PC and its physicians are the responsibility of the patient or the parent of a minor. As a courtesy, the office will complete a form for you to submit to your insurance carrier for your reimbursement. The patient or the parent of the minor is responsible for all fees, regardless of insurance coverage.

I agree to pay Rockland Thoracic and Vascular Associates PC and its physicians at the time services are rendered, unless other arrangements have been made in advance.

Patient's Initials **X** _____

INSURANCE INFORMATION AND ASSIGNMENT

I hereby authorize Rockland Thoracic and Vascular Associates PC and its physicians to furnish information to insurance carriers, including the Health Care Financing Administration and its agents, needed to determine benefits payable for related services.

I also request that payment of authorized benefits be made payable to me, or on my behalf, to Rockland Thoracic and Vascular Associates PC and its physicians, for any services rendered to me.

I understand that I am responsible for any amount not covered by insurance.

Patient's Initials **X** _____

PRIVACY ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. (Copy in office or on website, www.rocklandthoracicandvascular.com)

Patient's Initials **X** _____

Patient's Signature **X** _____

ROCKLAND THORACIC & VASCULAR ASSOC. P.C.
ROCKLAND VEIN CENTER

PATIENT NAME: _____ DATE: _____

DOB: _____ AGE: _____

REASON FOR TODAY'S VISIT: _____

REFERRING PHYSICIAN: _____ PHONE NUMBER: _____

PAST MEDICAL HISTORY: (please check all those that apply)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Heart Attack/MI |
| <input type="checkbox"/> Heart Failure/CHF | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Phlebitis/DVT | <input type="checkbox"/> Leg Ulcer | |
| <input type="checkbox"/> Vein Stripping | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Sclerotherapy | <input type="checkbox"/> Deep Vein Thrombosis |
| <input type="checkbox"/> Bleeding/Clotting | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Compression Stockings | <input type="checkbox"/> Vein Ablation (EVLT/VNUS) |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Swelling | <input type="checkbox"/> Discoloration | <input type="checkbox"/> Cosmetic Concerns |

PAST SURGICAL HISTORY (please supply procedure and dates)

MEDICATIONS: (please list all with dosage)

ALLERGIES: (latex, dye/contrast, bee stings, etc.)

TOBACCO HISTORY:

Never On Occasion Currently (quantity/years) _____ Quit (year) _____

ALCOHOL HISTORY:

Never On Occasion Currently (quantity) _____ Quit (year) _____

FAMILY HISTORY:

Mother: Alive Deceased Medical Problems: _____
Father: Alive Deceased Medical Problems: _____

RACE: White Hispanic Hawaiian Asian Black/African Other _____
ETHNICITY: Hispanic/Latino Not Hispanic/Latino