

Vascular Institute of New York
960 50th Street
Brooklyn, NY 11219
718-438-3800

Date: _____

**This form will assist us at the Vascular Institute of New York in gathering important information regarding your history. Please take the time to answer each question accurately and completely before you are seen by Dr. Enrico Ascher or Dr. Anil Hingorani*

PLEASE PRINT

Last Name: _____ First Name: _____ Age: ____ DOB: __/__/__

Address: _____ Apt #: _____ City: _____ ST: ____ Zip : _____

Race: Caucasian __ African American __ Hispanic __ American Indian __ Asian __

Language: _____

Social Sec #: _____ Male ____ Female ____ Email: _____

Home Tel: _____ - _____ - _____ Cell Ph: _____ - _____ - _____ Work #: _____ - _____ - _____

Emergency Contact: _____ Relation: _____ Tel: _____ - _____ - _____

Referring Physician: _____ Town: _____

Primary Care Physician: _____ Town: _____

Other Physicians you wish to receive information: _____

Pharmacy: _____ Town: _____ Tel: _____ - _____ - _____

Employer: _____ Address: _____

Primary Insurance: _____ ID#: _____ Grp #: _____

Secondary Insurance: _____ ID#: _____ Grp#: _____

Current Medications (Prescription and non-prescription):

Allergies to Food or Medications: _____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____

Please list all surgeries

1. _____
2. _____
4. _____
5. _____

3. _____

6. _____

Smoking History:

Have you ever smoked? Yes No How many packs? _____ How many years? _____ When did you quit? _____
Do you smoke now? Yes No How many packs per day? _____
Do you drink alcohol? Yes No How much alcohol do you drink per day? _____

Last Mammogram: _____ **Last Colonoscopy** _____ **Last Pneumonia Vaccine** _____

Review of Systems: Check (√) any condition you have or ever had:

	No	Yes
Hypertension	___	___
Weight Loss	___	___
Changes in Appetite	___	___
Muscle or Bone Pain	___	___
Extreme Fatigue	___	___
Asthma	___	___
Diabetes	___	___
Thyroid Disorder	___	___
Osteoporosis/Osteopenia	___	___
Stroke	___	___
Epilepsy	___	___
Gland Disorder	___	___
Shortness of Breath	___	___
Lung Problems	___	___
Pacemaker Insertion	___	___
Chest Pain/Angina	___	___
Heart Disease	___	___

****PLEASE BRING YOUR INSURANCE CARDS WITH YOU TO YOUR APPOINTMENT****

I authorize Vascular Institute of New York to release any information to expedite insurance claims. I hereby authorize and direct my insurance carrier to pay directly to Vascular Institute of New York any benefits due me under my insurance plan. If my insurance company does not have a contract for full payment for these services, I agree to pay the balance of expenses not paid under my plan. I am herewith supplying all of my insurance information (primary & secondary) to this provider at the time of service.

Patient Signature

Date

Physician Signature

Date