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