



**Patient Information Sheet** Date: \_\_\_\_\_ Email \_\_\_\_\_ Account # \_\_\_\_\_

Name, Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ M/F \_\_\_\_\_

Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age \_\_\_\_\_ SS # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone – Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Single  Married  Divorced  Separated  Widowed Guardian's Name if applicable \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

**Ethnicity/Race**  American Indian/Alaska Native  Black/African American  Asian  
 Native Hawaiian/Other Pacific Islander  Caucasian  Hispanic/Latino/Spanish Origin  No Response

**Preferred Language**  
English Spanish French Russian Italian Other \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Insurance –Primary** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Policyholder Date of Birth \_\_\_\_\_

Relationship to Patient  Self  Parent  Guardian  Spouse  Other \_\_\_\_\_

**Insurance-Secondary** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Policyholder Date of Birth \_\_\_\_\_

Relationship to Patient  Self  Parent  Guardian  Spouse  Other \_\_\_\_\_

PALISADES  VEIN CENTER  
& MEDICAL SPA

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Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

**Please list all physicians involved in your care:**

Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

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Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

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Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

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Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

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Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

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**PALISADES VEIN CENTER**  
 & MEDICAL SPA

Patient Name: \_\_\_\_\_ M/F \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Reason For Today's Visit:** \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Past Medical History:** (please circle all of those that apply)

- |                            |                      |                 |
|----------------------------|----------------------|-----------------|
| Deep Vein Thrombosis       | Heart Attack         | Swelling        |
| Superficial Vein Phlebitis | Diabetes             | Bruising        |
| Bleeding Disorders         | Elevated Cholesterol | Cosmetic Issues |
| Clotting Disorders         | Cancer (type) _____  | Leg Ulcers      |

**Past Surgical History:** (please supply procedure and dates):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medications:** Pharmacy: \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies/ Reactions:** (latex, dye/contrast, bee stings, etc.)

\_\_\_\_\_  
 \_\_\_\_\_

**Tobacco History:**

Never \_\_\_\_\_  Currently (packs per day/years) \_\_\_\_\_  Quit (year) \_\_\_\_\_

**Alcohol History:**

Never \_\_\_\_\_  Currently (packs per day/years) \_\_\_\_\_ Quit (year) \_\_\_\_\_

**Family History:** (Please circle)

Mother: Alive Deceased  Medical Problems: \_\_\_\_\_  
 Father: Alive Deceased  Medical Problems: \_\_\_\_\_

Have you gotten the Pneumonia Vaccine? Yes No Date Received \_\_\_\_\_  
 Have you gotten the Flu Vaccine? Yes No Date Received \_\_\_\_\_  
 Do you have a living will? Yes No

  
**PALISADES VEIN CENTER**  
& MEDICAL SPA

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Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

**Medical History**

The information concerning my medications and medical history is true and correct to the best of my belief.  
Patient's Initials \_\_\_\_\_

**Statement of Financial Responsibility**

All professional services rendered by Rockland Thoracic and Vascular Assoc., PC, Hudson Valley Thoracic Assoc., PLLC and its physicians are the responsibility of the patient or the parent of a minor. As a courtesy, our office will complete forms and submit to your insurance carrier for processing. 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 Assoc., PC, Hudson Valley Thoracic Assoc., PLLC and its Physicians, at the time services are rendered, unless other arrangements have been made in advance.  
Patient's Initials \_\_\_\_\_

**Authorization to release medical records to other physicians, hospitals and persons listed here.**

I hereby authorize Rockland Thoracic and Vascular Assoc., PC and Hudson Valley Thoracic Assoc., PLLC to make available to: (Name) \_\_\_\_\_ (Address) \_\_\_\_\_ complete information concerning the billing, medical findings and treatment of the above patient's medical treatment.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_.

**Note:** Written request is required to release records to others. If you do not wish to complete this portion of the form please sign here: \_\_\_\_\_ Witnessed by \_\_\_\_\_  
Date \_\_\_\_\_

**Insurance Information and Assignment**

I hereby authorize Rockland Thoracic and Vascular Assoc., PC, Hudson Valley Thoracic Assoc., PLLC 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 Rockland Thoracic and Assoc., PC, Hudson Valley Thoracic Assoc., PLLC and its physicians, for any services rendered to me.  
I understand that I am responsible for any amount not covered by insurance. Pt. Initials \_\_\_\_\_

**Privacy Acknowledgement**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. Pt. Initials \_\_\_\_\_

**Notice of Responsibility**

I understand that any required referrals/authorization by my insurance company, not supplied at the time of visit which may cause denial of payment for that service, will be my financial responsibility. Patient Initials \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Today's Date \_\_\_\_\_