Rockland Thoracic & Vascular Associates, P.C.
Hudson Valley Thoracic & Vascular Associates, P.L.L.C.
Rockland Center for Vascular Surgery
Bergen Thoracic and Vascular Associates, P.C.

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

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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 _____

5A Medical Park Drive Pomona, NY 10970 T:(845) 362-0075 F: (845) 362-1716	873 Route 45, Suite 104/105 New City, NY 10956 T:(845) 499- 2333 F: (845) 499-2336	70 Hatfield Lane, Suite 202 Goshen, NY 10924 T:(845) 291-3656 F: (845) 291-3936	350 Engle Street, Berrie Bldg, Suite 6501 Englewood, NJ 07631 T: (201) 569-1101 F: (201) 569-1108	25 Rockwood Pl, Suite 330 Englewood, NJ 07631 T: (201) 408-5195 F: (201) 569-1108

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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 (____)_____

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 (____)_____

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Patient Name: _____M/F____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Reason For Today's Visit:_____

Referring Physician:_____ Phone Number: _____

Past Medical History: (please check all those that apply)

- o High blood pressure
- o Diabetes
- o High cholesterol
- o PVD/PAD
- o Heart attack/MI
- o Emphysema/COPD
- o Lung disease
- o Esophageal disease
- o Stroke/TIA
- o Intestinal disease
- o Kidney disease
- o Autoimmune disease
- o Thyroid disease
- o Arthritis
- o Low-back problems
- o Varicose veins
- o Phlebitis/DVT
- o Bleeding/Clotting
- o Leg ulcer
- o Swelling
- o Sleep Apnea

Have you ever had cancer: No Yes: (type) _____

Have you had a Colonoscopy: No Yes: (Date)_____

Past Surgical History (please supply procedure and dates):

_____
_____
_____
_____

Medications : Pharmacy: _____Phone # _____
_____
_____
_____
_____

Medication Allergies/ Reactions: (please include *latex* or *contrast (dye)* or *shellfish* allergies)

_____
_____

Tobacco History:
____Never ____Quit (what year)_____ ____Currently(packs/day)_____. How many years?____

Alcohol History:
____Never ____Currently (quantity) Daily_____ Weekly_____ Type_____

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
If you are Diabetic, have you had a Diabetic Foot Exam? Yes No Date Received:_____

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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 _____