



Peripheral  
*Vascular*  
Surgeons

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HAVE YOU EVER BEEN SEEN BY ANY OF OUR DOCTORS BEFORE? YES \_\_\_\_ NO \_\_\_\_

Mr. \_\_\_\_\_  
Mrs. \_\_\_\_\_  
Miss \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle)  
Ms. \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(Street) (Apt.# / RD# / Box#) (City) (State) (Zip)

PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ WORK PHONE # \_\_\_\_\_

EMPLOYER \_\_\_\_\_

FAMILY DOCTOR'S NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

SENT TO US BY: \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY - NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_ WORK # \_\_\_\_\_

WHAT IS THE REASON FOR THIS VISIT? \_\_\_\_\_

MEDICAL HISTORY	YOURSELF	FAMILY	PAST MEDICAL HISTORY/SURGERIES/HOSPITALIZATIONS
DIABETES	_____	_____	_____
HIGH BLOOD PRESSURE	_____	_____	_____
HIGH CHOLESTEROL	_____	_____	_____
HEART DISEASE	_____	_____	_____
HEPATITIS	_____	_____	_____
STROKE	_____	_____	_____
ASTHMA, EMPHYSEMA	_____	_____	_____
BREATHING DIFFICULTY	_____	_____	_____
OTHER (PLEASE EXPLAIN) _____			_____
_____			_____
_____			_____

DO YOU SMOKE? \_\_\_\_\_ # PPD \_\_\_\_\_

LIST MEDICATIONS YOU ARE CURRENTLY TAKING:

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

ALLERGIES: \_\_\_\_\_

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

**LIST ALL INSURANCES FOR PATIENT (PLEASE PRESENT CARDS AT TIME OF VISIT)**

INSURANCE COMPANY NAME	POLICYHOLDER OR SUBSCRIBER	IDENTIFICATION NUMBER AND GROUP NUMBER
1. _____	_____	ID# _____
	EFFECTIVE DATE _____	GROUP# _____
2. _____	_____	ID# _____
	EFFECTIVE DATE _____	GROUP# _____

**IF YOU ARE COVERED BY MEDICARE, PLEASE ANSWER**

ARE YOU EMPLOYED? YES \_\_\_\_\_ NO \_\_\_\_\_

IS YOUR SPOUSE EMPLOYED YES \_\_\_\_\_ NO \_\_\_\_\_

ARE YOU COVERED BY THE GROUP HEALTH PLAN AT WORK? YES \_\_\_\_\_ NO \_\_\_\_\_

IS YOUR PROBLEM OR INJURY DUE TO ANY KIND OF ACCIDENT? YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, MOTOR VEHICLE? YES \_\_\_\_\_ NO \_\_\_\_\_ WORKMAN'S COMPENSATION? YES \_\_\_\_\_ NO \_\_\_\_\_

WILL THIS CLAIM BE COVERED UNDER WORKMAN'S COMPENSATION? YES \_\_\_\_\_ NO \_\_\_\_\_

IF WORKMAN'S COMPENSATION, TREATMENT AUTHORIZED BY \_\_\_\_\_

DATE OF ACCIDENT \_\_\_\_\_

**IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT OF SERVICES, PLEASE COMPLETE:**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

(Last) (First) (Middle)

ADDRESS \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

OCCUPATION \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

POWER OF ATTORNEY \_\_\_\_\_

I hereby authorize Peripheral Vascular Surgeons, P.C. to release any information acquired in the course of my examination or treatment for insurance claims, and authorize payment directly to Peripheral Vascular Surgeons, P.C., of the surgical and/or medical benefits, if any, otherwise payable to me for their services.

I request that payment of authorized Medicare and/or all medical insurance benefits be made on my behalf to Peripheral Vascular Surgeons, P.C., for any services furnished me for their services. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand I am financially responsible for all charges not covered by this authorization and guarantee payment of this account.

\_\_\_\_\_  
(Patient or Parent if Patient is Minor) (Date)

\* PLEASE COMPLETE AND BRING THIS FORM TO YOUR SCHEDULED APPOINTMENT