Florida Vascular Consultants, P.A.

Dr. G. K. Adcock [ ]	Dr. R. Winter [ ]	Dr. M. Perez-Izquierdo [ ]

Date: _____

Patient Name _____ Date of Birth_____Age ____

Gender: Male [ ] Female [ ] Race: _____ Ethnicity: _____

Address: _____ Apt# _____ Telephone Number: _____

City: _____ State: _____ Zip: _____ Mobile Number : _____

Email Address: _____ Social Security# _____

Employment/Spouse Information

Employer: _____ Work#: _____

Address: _____City: _____ State: _____ Zip: _____

Spouse Information:

Name: _____ Date of Birth: _____ Age: _____

Emergency Contact Information

Name: _____ Phone# _____ Relationship: _____

Doctor Information

Referring Or Primary Doctor: _____ Office#: _____

Cardiologist: _____ Office# : _____

Patient History

HAVE YOU EVER BEEN TREATED BY ANY OTHER PHYSICIAN FOR THIS CONDITION? Yes [] No []

If "YES" Doctors Name: _____ Office#: _____

When did symptoms 1ST occur: _____ Smoker [] Non-Smoker [] Diabetic []

Medication(s): _____ Allergies: _____

Insurance Information/ Assignment of Benefits/ Release Information

Primary Insurance: _____ Secondary Insurance:_____

*****Please be sure to provide Insurance Card so we may copy and file into medical chart. We bill as a courtesy to your insurance company. If the insurance information is incorrect or invalid, patient is responsible for all open charges. I understand that I will be financially responsible for all charges whether paid or not paid by my insurance company(s).**