Welcome To Our Office
Vascular & General Surgical Specialists of SWFL- VGSS

Patient Legal First Name: _____M.I: _____Last Name: _____

Home Address: _____City_____State_____Zip_____

Alternative Address: _____City_____ _____State_____Zip_____

Gender: ☐M ☐ F Social Security# (required):_____Date of Birth: ____/____/____

Home Phone #: _____ (☐Preferred) Mobile Phone #: _____ (☐Preferred)

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed E-mail:_____

Employment status: ☐Part Time ☐Full Time ☐Retired Name of Employer: _____

Ethnicity:☐ Hispanic/Latino ☐Not Hispanic/Latino ☐Patient Declined

Race: ☐Black/African American ☐American Indian ☐Asian ☐White ☐Hawaiian/Pacific Island ☐Other

Primary Language: ☐ English ☐Spanish ☐Other

How did you hear about us? ☐Referring Doctor ☐Friend/Family ☐Online ☐ Other: _____

Type of Insurance Plan: ☐HMO ☐PPO ☐ POS ☐Medicare ☐Military ☐Medicaid ☐Self Pay ☐Other: _____

Primary Insurance: _____Secondary Insurance: _____

Are you the policy holder for your primary insurance or secondary insurance? ☐Yes ☐No, **if NO see below**

Policy Holder's Name: _____DOB:_____SSN:_____

Relationship: _____

Emergency Contact Name: _____Relationship: _____

Phone #:_____Alt #:_____

What Pharmacy do you use: _____Phone#:_____

Address: _____City_____State_____Zip_____

By signing this form, you are granting consent to Vascular & General Surgical Specialists of SWFL to use and disclose your protected health information for purposes of treatment, payment, and health care operations. I authorize the release of my medical records to any physicians to whom I am referred. I acknowledge that a copy of the Privacy Notice has been made available to me.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at (239) 936-8575. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent. A copy of this form is to be considered valid as an original.

Signed: _____Date:_____