Vascular Center of the Midwest
Excellence in Comprehensive Vascular Care

Patient Information:

DATE:_____

DOB:_____ Sex: □ M □ F Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated □ Life Partner

Parent / Legal Guardian Name if patient is a minor Name:_____
DOB_____

Race □ White □ Black/African American □ American Indian/Alaska Native □ Asian □ Native Hawaiian/Pacific Islander □ Declined

Preferred Language: English_____ Spanish_____ _____ Other_____

Do you have any communication difficulties/ special needs? Hearing Loss Interpreter Required Reading Difficulty Sight Impaired Other

If yes, please list: _____

Address: _____Apt # _____ City_____St_____Zip _____

Phone: Home_____Cell_____ Work_____

E-Mail_____

Best Contact Method: □ Home □ Cell □ Work □ E-Mail □ Mail By checking one of the boxes for Best Contact Method, I agree to receiving correspondence from VCM

Employment Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Disabled □ Retired Employer/School:_____

FINANCIALLY RESPONSIBLE PARTY (If Different from patient, fill complete the section below):

Name: First_____MI_____ Last_____

Relationship: Spouse Parent Guardian Other (Please Specify): _____

Address: _____Apt #_____ City_____St_____Zip _____

Phone: Home_____ Cell_____ Work_____

Email Address _____

Employer: _____

EMERGENCY NOTIFICATION

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

REFERRAL SOURCE

□ Friend/Family Member □ Insurance Company □ Walk-in □ THR Referral Line □ Phone Book □ Direct Mail □ TV □ Radio □ Coach_____

□ Trainer_____ □ Newspaper_____□ Magazine _____ □ Web Search □ Practice Website □ Event

□ VCM Website □ Another Physician/Provider _____ □ CVS _____ □ Other _____

□ Other Advertisement _____ □ Hospital / ED _____