

Vero Vascular Surgery, P.A.

W. Clark Beckett, M.D., F.A.C.S.
Board Certified Vascular Surgeon

3770 7th Terrace, Suite 101 • Vero Beach, Florida 32960 • 772.567.6602 • Fax 772.567.7754

DATE: _____

PATIENT EMAIL: _____
(to receive emails on our latest vascular information)

How did you hear about our office? (circle one) Friend Press Journal Physician VB Magazine
Other _____

SECTION A: PATIENT INFORMATION

NAME: LAST _____ FIRST _____ INITIAL _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ DATE OF BIRTH _____

SECONDARY ADDRESS _____

CITY _____ ST _____ ZIP _____ PHONE _____

PATIENT SOCIAL SECURITY # _____ MARITAL STATUS _____

PERSON RESPONSIBLE FOR BILL _____ REFERRED BY _____

EMPLOYER _____ OCCUPATION _____

STREET ADDRESS _____ CITY _____ ST _____ ZIP _____

PHONE # _____

SECTION B: SPOUSE INFORMATION

NAME _____ DATE OF BIRTH _____ SOC.SEC.# _____

EMPLOYER _____ OCCUPATION _____

STREET ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

SECTION C: IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME _____ RELATIONSHIP _____ PHONE _____

RELATIVE _____ RELATIONSHIP _____ PHONE _____

SECTION D: (circle answer)

Is Medicare your Primary? YES NO Is your Medicare a PFFS, PPO or HMO MC? YES NO

Do you have Medicare Part B? YES NO

SECTION E: **If insurance cards are copied skip this section**

PRIMARY INSURANCE

INS.CO.NAME _____

INSURED _____ RELATIONSHIP _____

ID# _____ GROUP# _____

SECONDARY INSURANCE

INS.CO.NAME _____

INSURED _____ RELATIONSHIP _____

ID# _____ GROUP# _____

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PATIENT HISTORY FORM

Name _____ D.O.B. _____

Date of visit _____ Telephone(H) _____ (C) _____ Age _____

Referring Physician _____

Chief Complaint _____

(Nurse will record BP) Blood Pressure Left _____ Right _____ Pulse _____

PERSONAL HABITS:

1. Tobacco Use: No _____ Yes _____ How Much _____ Quit _____ How Long Ago _____

2. Alcohol Use: No _____ Yes _____ How Much _____ Quit _____ How Long Ago _____

3. Caffeine Use: No _____ Yes _____ How Much _____ Quit _____ How Long Ago _____

4. Exercise Program: No _____ Yes _____ Describe: _____

GENERAL INFORMATION:

1. Allergies: _____

2. Current Medications:

3. Surgeries: (Include Dates)

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MEDICAL HISTORY: (Please check all that apply)

GENERAL:	Yes	No	RESPIRATORY:	Yes	No
Headaches	___	___	Difficulty Breathing	___	___
Dizziness	___	___	Chronic Cough	___	___
Blurred/Double Vision	___	___	Asthma	___	___
Cataracts	___	___	Emphysema	___	___
Dentures	___	___			
NEUROLOGICAL:			DIGESTIVE:		
Seizures	___	___	Heart Burn	___	___
Paralysis	___	___	Nausea/Vomiting	___	___
Tremors	___	___	Constipation	___	___
TIA's	___	___	Ulcer Disease	___	___
Stroke	___	___			
Parkinson's	___	___	KIDNEY/BLADDER:		
Alzheimer's	___	___	Frequent Urination	___	___
			Incontinence	___	___
CARDIOVASCULAR:			Difficulty Urination	___	___
Chest Pain	___	___	Kidney Disease	___	___
Murmur	___	___			
High Blood Pressure	___	___	MUSCLES/BONES/JOINTS:		
High Cholesterol	___	___	Back Pain	___	___
Irregular Heart Beat	___	___	Muscle Weakness	___	___
Congestive Heart Failure	___	___	Arthritis	___	___
Heart Attack	___	___	Osteoporosis	___	___
Pacemaker	___	___			
PVS:			HEMAT/LYMPH/IMMUNO:		
Varicose Veins	___	___	Anemia	___	___
Spider Veins	___	___	Bleeding Tendency	___	___
Leg Pain-----at rest	___	___	Hepatitis, Type _____	___	___
Walking	___	___	Cancer, Type _____	___	___
Deep Vein Clot	___	___	Peripheral Neuropathy	___	___
Superficial Phlebitis	___	___	Liver Disease	___	___
			Diabetes, Type _____	___	___

Do you have any other Health care concerns not mentioned previously _____

Patient Name: _____ DOB: _____