



VASCULAR & TRANSPLANT
SPECIALISTS

PATIENT INFORMATION SHEET

Gregory A. Barber, MD, FACS
John O. Colonna, II, MD, FACS
Richard J. DeMasi, MD, FACS, RVT
Martin A. Fogle, MD, FACS
Robert G. Gayle, MD, FACS, RVT

Todd W. Gensler, MD, FACS
Marc H. Glickman, MD, FACS
Michael J. Marcinczyk, MD, FACS, RVT
C. Scott McEnroe, MD, FACS
George H. Meier, III, MD, FACS, RVT

Peter M. Moy, MD, FACS
Jean M. Panneton, MD, FACS, FRCSC
Noel Parent, III, MD, FACS, RVT
Rasesh M. Shah, MD, FACS
Gordon K. Stokes, MD, FACS

Name: _____ Address: _____

City, State, Zip: _____ Telephone: _____ E-mail Address _____

DOB: _____ Sex: _____ Social Security Number _____ Marital Status: _____

Employer: _____ Occupation: _____

Employer Address: _____ Telephone Number: _____

Name of Spouse: _____ Birth Date: _____

SS #: _____ Occupation: _____

Employer: _____ Address: _____ Telephone: _____

Name of Friend/Relative Not in Household: _____ Relationship to Patient: _____

Address: _____ Telephone: _____ Referred By: _____

I hereby apply for treatment by the above physicians, their associates and or assistants. Treatment may include injections and/or such other office procedures they deem necessary.

I authorize the release of information necessary for the filing of any insurance and the direct payment to the above physicians of any amounts due on my claim on any policy that I may have.

I understand that filing of my insurance by Vascular & Transplant Specialists is done as a courtesy and that I am financially responsible for any balance remaining. In the event that my account is referred to any attorney, I agree to pay all costs of collection, including an attorney's fee of 33 1/3% of the balance owing at the time of referral to the attorney.

I hereby authorize you to release to Vascular & Transplant Specialists any information including the diagnosis, records, and/or reports of any treatment or examination rendered to me. I understand these records are needed to help further my treatment and diagnosis and will be used for these purposes only.

Date _____ Patient Signature _____