

JOHN P. LANDI, M.D.
VASCULAR & GENERAL SURGERY

Date: _____

Name: _____ **Telephone:** _____

Cell: _____

E-Mail: _____

Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Social Security No: _____ **Date of Birth:** _____

Age: _____ **Sex (Circle) M F** **Occupation:** _____

Name of Employer: _____

Address: _____

Business Telephone: _____

If Married Name of Spouse: _____ **Spouse Phone:** _____

Referred to us by: _____

Primary Insurance: _____ **Medicare #:** _____

Blue Cross Blue Shield _____

Other: _____

Secondary Insurance: _____

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Primary Doctor:

Name: _____

Address: _____

Telephone: _____

ALLERGIES: List all medication and food that you are allergic to:

MEDICATION: List all medications and vitamins that you are currently taking:

PREVIOUS SURGERIES:

PLEASE ANSWER THE FOLLOWING:

Current Smoker: Yes _____ No _____ If yes, how long? _____
Have you ever smoked? Yes _____ No _____ If so, how long? _____
Diabetes: Yes _____ No _____ If yes, medication _____
Hypertension: Yes _____ No _____ If yes, medication _____
High Cholesterol: Yes _____ No _____ If yes, medication _____
Do you drink alcohol? Yes _____ No _____ If yes, how much? Daily _____ Occasionally _____

FAMILY HISTORY:

Diabetes: Yes No
Heart Problem: Yes No
Cancer: Yes No
Stroke: Yes No

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PLEASE ANSWER THE FOLLOWING:

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name: _____

Address: _____

Phone Number: _____

Signature: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependent. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or Dependent and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Name: _____ hereby authorize _____
To pay and hereby described on the attached form. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits when received by and paid to John P. Landi, M.D. will be credited to my account in accordance with the above said assignment.

Signature: _____ Date: _____