

# WESTCHESTER SURGERY, P.C.

**Ogedi A. Ohajekwe, M.D., RVT**  
Vascular Surgery-General Surgery  
1 Pondfield Road West, Suite 51-A Bronxville, NY 10708  
Phone (914) 337-9295

## Patient Information Form

\*Please provide copy of insurance card front and back  
**PLEASE PRINT ALL INFORMATION CLEARLY**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Tel #: \_\_\_\_\_ Work Tel #: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

**Primary Physician:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tele #: \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ Tel: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_

Policy/Group # \_\_\_\_\_ I.D.# \_\_\_\_\_

Relationship to Insured (self, child, spouse, other): \_\_\_\_\_

Name of Insured Party: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Social Security# \_\_\_\_\_ Co-Pay: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Policy/Group # \_\_\_\_\_ I.D.# \_\_\_\_\_

Relationship to Insured (self, child, spouse, other): \_\_\_\_\_

Name of Insured Party: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Social Security # \_\_\_\_\_ Co-Pay \_\_\_\_\_

### Signature Release

I hereby authorize that Medicare benefits or other insurance benefits be made directly to Westchester Surgery, P.C., on any unpaid bills for services provided. I also hereby authorize the holder of medical or other information about me to release all relevant information for determination of these payments. I understand that I may be financially responsible for any co-payment, deductible, or for any balance not covered by my insurance carrier.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CONSULTATION FORM

**Medical problems:**

Coronary heart disease \_\_\_\_\_ Diabetes \_\_\_\_\_ High blood pressure \_\_\_\_\_ Cancer (specify) \_\_\_\_\_

Low blood pressure \_\_\_\_\_ Previous major surgery (specify) \_\_\_\_\_

Do you have religious objections to blood transfusion? \_\_\_\_\_

Have you ever received blood transfusion? Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes When? \_\_\_\_\_

**Are you taking any medications regularly?**

<u>Medication</u>	<u>Name of Medication</u>	<u>Dosage</u>
_____ Aspirin	_____	_____
_____ Digitalis (Lanoxin)	_____	_____
_____ Insulin	_____	_____
_____ Steroid	_____	_____
_____ Anti-seizure	_____	_____
_____ Diuretic	_____	_____
_____ Antidepressant	_____	_____
_____ Blood Thinner	_____	_____
_____ Other cardiac medication	_____	_____

Other medications: \_\_\_\_\_

**Allergies and Sensitivities:** \_\_\_\_\_

**Reaction:** \_\_\_\_\_

**Family History:**

Mother: Living \_\_\_\_\_ Age? \_\_\_\_\_ Deceased \_\_\_\_\_ Age at death? \_\_\_\_\_ Cause of death \_\_\_\_\_

Father: Living \_\_\_\_\_ Age? \_\_\_\_\_ Deceased \_\_\_\_\_ Age at death? \_\_\_\_\_ Cause of death \_\_\_\_\_

**Any family history of:**

Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Alcoholism \_\_\_\_\_ Heart disease \_\_\_\_\_  
High blood pressure \_\_\_\_\_ Neurological disease \_\_\_\_\_ Psychiatric illness \_\_\_\_\_ Stroke \_\_\_\_\_  
Blood clot \_\_\_\_\_ High cholesterol \_\_\_\_\_ Kidney disease \_\_\_\_\_ Thyroid disease \_\_\_\_\_  
Breast cancer \_\_\_\_\_

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***Occupation and name of employer:*** \_\_\_\_\_

***Tobacco?*** Yes \_\_\_\_\_ # of years \_\_\_\_\_ Never \_\_\_\_\_ Stopped \_\_\_\_\_ How long ago? \_\_\_\_\_

***Alcohol:*** Yes \_\_\_\_\_ Beer \_\_\_\_\_ Wine \_\_\_\_\_ Liquor \_\_\_\_\_ Never \_\_\_\_\_ Average drinks/week \_\_\_\_\_

Stopped: Yes \_\_\_\_\_ No \_\_\_\_\_ How long ago \_\_\_\_\_

***Do you exercise?*** Yes \_\_\_\_\_ No \_\_\_\_\_ How often? \_\_\_\_\_

Have you had any of the following? Check the ones that apply.

- |   |   |
|---|---|
| _____ Recent gain or loss of weight                     | _____ Sudden vision loss, blurry vision                 |
| _____ Unusually severe headaches                        | _____ Ear, nose or throat problems                      |
| _____ Persistent fever, chills or night sweats          | _____ Shortness of breath, wheezing                     |
| _____ Glaucoma  | _____ Persistent coughing up blood                      |
| _____ Tightness, pressure, or pain in the chest         | _____ Pneumonia, emphysema                              |
| _____ Racing or skipping heart beats                    | _____ Any other lung problems                           |
| _____ History of mitral-valve prolapse                  | _____ Loss of appetite                                  |
| _____ Persistent swelling of feet or ankles             | _____ Stomach pain                                      |
| _____ Blood in the stool, or black stool                | _____ Persistent nausea or vomiting                     |
| _____ Ulcers, gall bladder disease, or hepatitis        | _____ Heart burn  |
| _____ Stiffness, pain or swelling in any joints         | _____ Difficulty starting or stopping urination         |
| _____ Seizures, fainting or blackouts                   | _____ Weakness, numbness or tingling in arm or legs     |
| _____ Problems with coordination or speech              | _____ Multiple sclerosis, Parkinson's disease or stroke |
| _____ Easy bruising or excessive bleeding               | _____ Any unusual vaginal bleeding                      |
| _____ Blood clot in the leg or lung                     |   |
| _____ Psychiatric illness                               |   |
| _____ Pain in the calf while walking                    |   |
| _____ Treatment of skin rashes, cancer or unusual moles |   |
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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read the notice carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling or writing the privacy officer.

Date: \_\_\_\_\_

\*Signature: \_\_\_\_\_

\*As the representative of the above individual, I acknowledge the receipt of the Notice on his or her behalf.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_