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Interventional and Vascular Consultants, PC

Name: _____

DOB: _____

At Interventional and Vascular Consultants, we hold your privacy to the highest regards. We would like to relay important medical information to you.

May we leave messages regarding important medical information?

- YES
- NO

What is the best way for us to contact you?

Phone: _____

Email: _____

Is there anyone you do want us to share information with?

If there is a need for medication, what pharmacy should we contact?

Name: _____

Address: _____

Phone: _____

Patient signature: _____

Date: _____