

R. Randolph Waterford, MD, FACS, RVT, RPVI Patient Intake Form

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Patient Name:			Date:		
First	Middle	Last			
Social Security #:	Date of Birth:	Age:	Height:	Weight:	
Home Address:	City:		State:	Zip:	
Home Phone:	Cell:	E-mail:			
Gender: ○ Male ○ Female	Marital Status: ○ Single	○ Married ○ Divore	ced		
Ethnicity: O Hispanic O Non-His	panic O Other:				
Race: O Asian O Native Hawaiia	n/Pacific Islander O White O Af	frican American \circ Ar	nerican Indian \circ	Other:	
Employer:	Occupation:		Work Phone:		
Employer Address:	Cit	y:	State:	Zip:	
Emergency Contact:	Relationship:	Ph	one:		
Primary Physician:	Preferred Pharmacy				
TREATMENT AUTHORIZATION I hereby authorize the Waterford related services on my behalf.	Vein Institute of Hawaii to perfo	orm and/or initiate m	nedical evaluation	and treatment and any	
Signature:		Date:			
How did you hear about our office	e?				