

OFFICES IN WESTPORT, CT  
& NEW YORK CITY

**LOCATION:** 304 Park Avenue South, 11<sup>th</sup> Floor  
**CROSS STREET:** E. 23<sup>rd</sup> Street

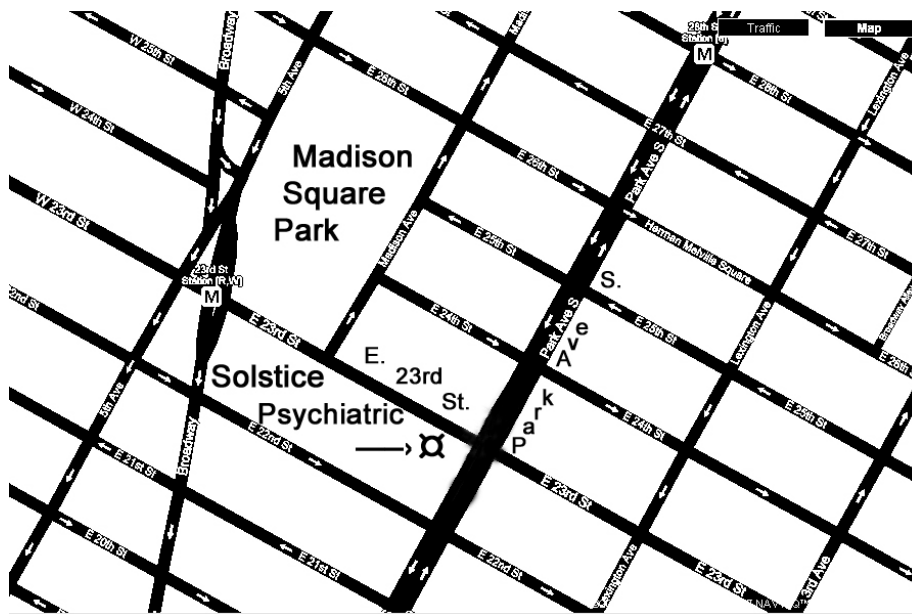
**NOTE:** enter from the SW corner of E. 23<sup>rd</sup> St,  
between Time Warner Cable and Radio Shack

**CLOSEST SUBWAY STOP:** E. 23<sup>rd</sup> Street Station on the 6 line  
Also close: E. 23<sup>rd</sup> St. stops on the R or W lines

**CLOSEST PARKING GARAGE:** E. 21<sup>st</sup> St. (between Park & Broadway)

**BUILDING ENTRANCE:** on SW corner of Park Ave. S. & E. 23<sup>rd</sup>

From subway stop, exit onto E. 23<sup>rd</sup> & walk west on the south side of the street. The building entrance is next door to the Time Warner Cable office and has an awning which reads "304"



**UPON ARRIVAL:** Notify the receptionist that you have an appointment with Dr. Thakkar, or Solstice Consulting

**\*\* If you have an appointment outside of business hours, please use the phone in the waiting room to dial 2330 (or the main number—646-706-7757 from a cell phone) to ring the office to indicate your arrival \*\***



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

**NAME:** First: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Marital Status: **S / M / D / W**

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

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

Email address: \_\_\_\_\_ .....OK to use? **Y / N**  
OK to leave messages?:

Home Tel: \_\_\_\_\_ .....**Y / N**

Work Tel: \_\_\_\_\_ .....**Y / N**

Mobile Tel: \_\_\_\_\_ .....**Y / N**

Occupation: \_\_\_\_\_ Hours worked per week: \_\_\_\_\_

Employer (name of school if student): \_\_\_\_\_

**Health Insurance:** *(please bring your insurance & Rx card(s) with you to the first appointment)*

Do you have health insurance? **Y / N** Medicare? **Y / N** Medicaid? **Y / N**

Other? **Y / N** Prescription coverage? **Y / N**

**Emergency Contact Info:** *(please provide at least two methods of contact including one telephone number)*

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

Address: \_\_\_\_\_ Home Tel: \_\_\_\_\_

\_\_\_\_\_ Mobile Tel: \_\_\_\_\_

Email Address: \_\_\_\_\_ Work Tel: \_\_\_\_\_

*How did you hear about my services?* \_\_\_\_\_

*What is your reason for making an appointment?* \_\_\_\_\_

*for security, please do not email this form; fax to:646-706-7757, scan & upload to:  
<https://forms.hush.com/vatsal.thakkar> or bring the completed forms to your appointment*



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

**PRIMARY CARE PROVIDER:**  check if none

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

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

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Frequency of visits: \_\_\_\_\_

**PSYCHOLOGIST OR THERAPIST:**  check if none

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

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

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Frequency of visits: \_\_\_\_\_

**CURRENT/FORMER PSYCHIATRIST:**  check if none

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

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

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Frequency of visits: \_\_\_\_\_

*These are for our records only and any communication with the above named providers will only occur with your signed authorization.*



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**CURRENT MEDICATIONS:**

*including OTC (over-the-counter) drugs, herbal remedies, and nutritional supplements, both daily and occasional use:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES** (to medications or foods): \_\_\_\_\_

**SPECIALISTS SEEN:** (at any point in the past)

- allergist
- endocrinologist
- gastroenterologist
- hematologist
- neurosurgeon
- cardiologist
- cardiothoracic surgeon
- general surgeon
- plastic surgeon
- pain specialist
- orthopedic surgeon

- infectious disease specialist
- nephrologist
- dermatologist
- cardiologist
- ENT specialist (ear/nose/thrt)
- urologist
- rheumatologist
- oral surgeon
- pulmonologist
- oncologist

- neurologist
- sleep specialist

OTHER THAN ROUTINE:

- OB/Gyn
- ophthalmologist
- internist
- OTHER \_\_\_\_\_
- NONE OF THE ABOVE

**MEDICAL CONDITIONS:** (please list all medical conditions that you have been evaluated for, diagnosed with, and/or treated for, both current and past):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HOSPITALIZATIONS, SURGERIES, & EMERGENCY ROOM VISITS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you ever had:**

- seizures
- heart palpitations
- fracture or severe injury
- blackouts
- chest pain
- a head injury/concussion
- fainting spells
- shortness of breath/asthma
- NONE OF THE ABOVE

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