PATIENT INFORMATION

Date _____

(Please Print)

Name of Referring Physician: _____

PATIENT'S LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NUMBER	MARITAL STATUS S M W D	SEX M F	BIRTH DATE	AGE

STREET ADDRESS	CITY/STATE	ZIP

HOME PHONE	BUS PHONE & EXT. #	CELL PHONE
( )	( )	( )

PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)

EMPLOYER'S STREET ADDRESS	CITY/STATE	ZIP

SPOUSE'S NAME	SOCIAL SECURITY NUMBER	BIRTH DATE

SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	BUS. PHONE #
		( )

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

EMAIL ADDRESS - Please provide us with your E-MAIL ADDRESS for special offers.

NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE NUMBER: _____

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE	ZIP CODE	HOME PHONE #

MEDICARE # ☐	EFFECTIVE DATE

BLUE SHIELD (GIVE NAME OF POLICYHOLDER)	EFFECTIVE DATE	CERTIFICATE #	GROUP #	COVERAGE CODE

HMO (WRITE IN NAME OF INSURANCE COMPANY)	EFFECTIVE DATE	POLICY #

NAME OF PRIMARY CARE PHYSICIAN (PCP)

OTHER (WRITE IN NAME OF INSURANCE COMPANY)	EFFECTIVE DATE	POLICY #

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.

_____ _____

SIGNATURE OF PATIENT, PARENT OR RESPONSIBLE PARTY DATE (Today)

ASSIGNMENT OF INSURANCE BENEFITS AND/OR RELEASE OF INFORMATION AUTHORITY

I authorize any holder of medical or other information about me to release to the Social Security Administrations and Health Care Financing, my insurance company, and/or its intermediaries and carriers any information needed for this or a related insurance claim. I permit a copy of this authorization be used in place of the original and I request payment of medical insurance benefits be paid either to myself or to VEINTEC VARICOSE VEIN CLINICS for any services furnished me by their physicians.

_____ _____

SIGNATURE OF PATIENT, PARENT OR RESPONSIBLE PARTY DATE (Today)

PLEASE NOTE - **BOTH** SIGNATURE SPACES MUST BE SIGNED IN ORDER FOR US TO FILE YOUR INSURANCE.