# PATIENT INFORMATION

Date _____

**Name of Referring Physician:** _____

**Name of Primary Care Physician (PCP):** _____

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

| 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 | BIRTH DATE |
|---|---|
| | |

| SPOUSE'S EMPLOYER | OCCUPATION (INDICATE IF STUDENT) | CONTACT # |
|---|---|---|
| | | (  ) |

| EMPLOYER'S STREET ADDRESS | CITY AND STATE | ZIP CODE |
|---|---|---|
| | | |

| EMAIL ADDRESS - Please provide us with your E-MAIL ADDRESS for special offers. | Do we have consent to use before and after photos without your name (only initials) for advertising? Check box with (  ) Yes or (  ) No |
|---|---|
| | |

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

IF THE PATIENT LISTED ABOVE IS **NOT** RESPONSIBLE FOR PAYMENT ON THIS ACCOUNT, PLEASE COMPLETE THE FOLLOWING:

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

| MEDICARE # ☐ EFFECTIVE DATE | SOCIAL OF SUBSCRIBER |
|---|---|
| | |

| PRIMARY (WRITE IN NAME OF INSURANCE COMPANY) | EFFECTIVE DATE | POLICY # |
|---|---|---|
| | | |

| SECONDARY (WRITE IN NAME OF INSURANCE COMPANY) | EFFECTIVE DATE | GROUP # | 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.