THE VEIN CLINIC, INC.
PATIENT REGISTRATION

2012

PATIENT NAME:______________________________

ADDRESS:______________________________

CITY, STATE, ZIP:______________________________

DATE OF BIRTH:______________ AGE:__________

SOCIAL SECURITY NUMBER:__________________

□ SINGLE □ MARRIED □ OTHER

SEX: □ MALE □ FEMALE

HEIGHT: ____________ WEIGHT: ____________

EMPLOYER/SCHOOL NAME & ADDRESS:

____

____

ACCOUNT #: ____________________

HOME PHONE:____________________

WORK PHONE:____________________

CELL PHONE: ____________________

PAGER: ________________________

WHAT ARE YOU BEING SEEN FOR?

____

____

____

ANY FOOD OR DRUG ALLERGIES?

____

____

____

INSURANCE INFORMATION:

PRIMARY INSURANCE

INSURANCE NAME:____________________

POLICY HOLDER'S NAME:____________________

POLICY HOLDER'S SSN:____________________

RELATIONSHIP TO PATIENT:__________________

EMPLOYER:____________________

POLICY HOLDER'S SEX: □ MALE □ FEMALE

POLICY HOLDER'S DATE OF BIRTH:____________

SECONDARY INSURANCE

INSURANCE NAME:____________________

POLICY HOLDER'S NAME:____________________

POLICY HOLDER'S SSN:____________________

RELATIONSHIP TO PATIENT:__________________

EMPLOYER:____________________

POLICY HOLDER'S SEX: □ MALE □ FEMALE

POLICY HOLDER'S DATE OF BIRTH:____________

ARE YOU PREGNANT? □ YES □ NO

HOW WERE YOU REFERRED TO OUR OFFICE?

□ EMPLOYER □ CO-WORKER

□ RELATIVE □ YELLOW PAGES

□ WALK- IN □ INS. PROVIDER BOOK

□ OTHER: ____________________

IN CASE OF EMERGENCY, NAME & PHONE NUMBER OF NEAREST RELATIVE:

____

____

____

____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this physician to release any information required in the course of my examination or treatment to my insurance company and/or to any other provider.

SIGNED:______________________________ DATE:____________________

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business of this physician for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

SIGNED:______________________________ DATE:____________________