veinclinics of America
An IntegraMed® Specialty

IntegraMed® Interventional
The Vein and Vascular Experts

PATIENT INFORMATION

NAME (First) ______________________________ (MI) _________ (Last) ___________________________________

ADDRESS ____ DATE OF BIRTH ______ / ______ / _____

CITY ________________________ STATE _______ ZIP CODE ________ HOME PHONE______________________

Sex: ☐ Male ☐ Female **Marital Status:** ☐ S ☐ M ☐ D ☐ W

PATIENT INFORMATION:	**SPOUSE INFORMATION:**
Occupation:	Spouse Name:
Work Phone:	Occupation:
Employer:	Work Phone:
City & State:	Employer:
Social Security:	City & State:
Email Address:	Social Security:
Cell Phone:	Date of Birth:

How did you find out about us?

☐ Radio ___________ *(Station)* ☐ TV ____________ *(Station)* ☐ Internet ___________________ *(Website)* ☐ Magazine ___________________ *(Name)*

☐ Friend/Family Member _____________________ *(Name)* ☐ Referral from Physician *(See Below)* ☐ Event _____________________ *(Name)*

☐ Pharmacy __________________ *(Name)* ☐ Other _________________________

Physician That Referred You

Name _______________________________________ Specialty_____________________ Phone ___________________

Address _______________________________________ City _____________________ State _______ Zip ___________

Primary Care Physician (if other than referring physician)

Name _______________________________________ Specialty_____________________ Phone ___________________

Address _______________________________________ City _____________________ State _______ Zip ___________

May we contact this Physician? Yes ☐ No ☐

OB/GYN Physician (if other than referring physician)

Name ____ Phone ___________________

Address _______________________________________ City _____________________ State _______ Zip ___________

May we contact this Physician? Yes ☐ No ☐

Insurance Information:

Primary _______________________ Group or ID # _______________ Insured's Name ____________________________

Secondary _____________________ Group or ID # _______________ Insured's Name ____________________________

In Case of Emergency, Contact ____ Phone __________________________

I authorize IntegraMed Interventional to execute any documents necessary, and release to my health insurance carrier, or other organization as required, any pertinent medical information about myself as may be required to process claims for reimbursement of fees charged to me for medical treatment at IntegraMed Interventional.

Signature: ____ Date: _________________________