vein clinics of America

Patient Information

Name (First) _____ (MI) _____ (Last) _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email Address _____ DOB ___/___/___ Social Security _____

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

Occupation _____ Employer _____

Work Phone _____ City _____ State _____

Insurance Information: ☐ Patient ☐ Spouse (If neither patient or spouse policy holder DOB ___/___/___)

Primary _____ Group _____ ID # _____ Insured's Name _____

Secondary _____ Group _____ ID # _____ Insured's Name _____

Spouse Information:

Name _____ DOB ___/___/___ Social Security _____

Occupation _____ Employer _____

Work Phone _____ City _____ State _____

How did you find out about us?

☐ Referral from Physician _____ (Name) ☐ Friend/Family Member _____ (Name)

☐ Radio _____ (Station) ☐ TV _____ (Station) ☐ Internet _____ (Website) ☐ Other _____ (List)

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 _____

OB/GYN Physician (if other than referring physician)

Name _____ Phone _____

Address _____ City _____ State ____ Zip _____

In Case of Emergency, Contact _____ **Phone** _____

I authorize Vein Clinics of America 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 Vein Clinics of America.

Signature _____ Date _____

Authorization for Communication of Protected Health Information

Patient Name (print) Date of Birth Chart Number

It is frequently necessary for personnel at this practice to communicate lab results, instructions, information about treatment, payment and other items of protected health information with our patients. It is frequently not possible to speak personally with the patient to leave this information. In the event that our personnel are not able to speak with you (the patient) directly, please give us instructions about communicating it to you.

1. Messages may be left on my home answering device @ _____

2. My home answering device does not identify me by name, but it is appropriate to leave messages for me there. (circle) yes or no

3. Messages may be left for me on my work voicemail @ _____

4. Messages may be left for me on my cell phone voicemail @ _____

5. Messages may be communicated by texting on my cell phone @ _____

6. Messages may be left for me with my partner (name) _____

7. Messages may be communicated to me via email @ _____

8. Other person(s) authorized to receive messages on my behalf:

   A) Name _____ @ _____

   B) Name _____ @ _____

I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time. This consent is valid for one year from the date of signature unless otherwise revoked in writing.

Signature of Patient or Patient/Guardian Date

_____

Relationship to Patient if Minor