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 _____