



## 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 \_\_\_\_\_  Friend/Family Member \_\_\_\_\_  
(Name) (Name)

Radio \_\_\_\_\_  TV \_\_\_\_\_  Internet \_\_\_\_\_  Other \_\_\_\_\_  
(Station) (Station) (Website) (List)

### Physician That Referred You

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

### Primary Care Physician (if other than referring physician)

Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

### OB/GYN Physician (if other than referring physician)

Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

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 \_\_\_\_\_