PATIENT REGISTRATION

Total Vein Care

Patient Information

Name: _____ DOB:_____

c/o Name, if patient is a minor:_____

_____
street

_____
city *state* *zip code*

_____
cell #

_____
home #

_____
work #

Preferred contact: ☐*cell* ☐*home* ☐*work*

_____
e-mail

SSN: _____ DL#: _____ ☐Male ☐Female

Employment/School: _____ ☐ Full ☐ Part

Race

- ☐ African or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Pacific Islander
- ☐ White
- ☐ Native Hawaiian
- ☐ Hispanic
- ☐ Refuse to answer
- ☐ Other _____

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refuse to Answer

Language

- ☐ English
- ☐ Spanish
- ☐ Other _____
- ☐ Refuse to answer

How did you hear about us? _____

Insurance & Medical Release

Person for release of medical information: _____
name *phone number*

To decline, sign here: _____ **without designated member listed, we cannot release your information to them.*

Primary Insurance: _____ Referring Dr. : _____

Secondary Insurance:_____ Primary Dr. : _____

I, the undersigned, authorize the release of any medical or insurance information to the stated insurance company necessary to process insurance claims for services rendered by the facility. I hereby authorize *Vascular Specialty Center and Vascular Specialty Laboratory, Inc.* to distribute the payment of my (or my dependents) medical coverage directly to the provider rendering services. I understand that I am fully responsible for all charges regardless of my insurance benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____