VeinCare Experts

Patient Registration

PATIENT INFORMATION

Last Name | First Name | M.I.			Today's Date
Date of Birth	Social Security No.	Sex: ☐ Male ☐ Female	Martial Status:
Home Address			
City | State | Zip			
Home Phone	Cell Phone	Work Phone	Email
Preferred method of contact for appointment reminders ☐ Home ☐ Cell ☐ Work ☐ Email		Preferred method of contact for billing/health information ☐ Home ☐ Cell ☐ Work ☐ Email	
Occupation		Employer	
Emergency Contact:		Phone	Relationship to Patient
Protected health information may be shared with:		Phone	Relationship to Patient

INSURANCE INFORMATION *(please give insurance card to receptionist)*

Person responsible for bill	Phone
Home Address (if different)	
Primary Insurance	
Policy Holders Name	Relationship
Secondary Insurance	
Policy Holders Name	Relationship

Authorization to release medical information and assignment of insurance benefits
The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize VeinCare Experts to release any information required to process my claims.

Patient Signature	Date