

PATIENT INFORMATION

Patient Information

Last Name _____ First _____ MI _____

DOB _____ Sex _____ SSN _____ Marital Status: _____

Primary Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Other Phone _____

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

I would like to receive promotional material by email or mail. Email Address: _____

Emergency Contact Information

Name _____ Phone _____ Relationship _____

Insurance Information

Primary Insurance _____ Policy # _____

Policy Holder _____ Group # _____

Phone # _____

Secondary Insurance _____ Policy # _____

Policy Holder _____ Group # _____

Phone # _____

Authorization for Release Information: I am authorizing Vanishing Veins to release all medical information (including, but not limited to, information on psychiatric conditions, alcohol and drug abuse) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize Vanishing Veins to release all medical information on to my referring physician and my primary physician. I authorize Vanishing Veins to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Vanishing Veins.

Assignment of Benefits: I request that payment of authorized insurance benefits be made on my behalf to Vanishing Veins. I agree that these provisions will remain in effect until I provide written revocation to Vanishing Veins.

Patient/Guardian Signature _____ Date _____

Guardian Name (if applicable) _____

THIS SECTION TO BE FILLED OUT BY OFFICE PERSONNEL.

Benefits Verified by Customer Service Representative: _____

Effective Date _____ # Visits Allowed _____ # Visits Used _____

Co-Pay _____ Deductible _____ Deductible Met _____

Authorization _____ Referral _____ Testing _____