

VASCULAR SURGICAL ASSOCIATES, P.C.

PATIENT INFORMATION

(Please Print)

Date: ____/____/____ Chart No.: _____ Employee Init.: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State/Zip: _____

Home Phone: () _____ Cell/Pager: () _____ Date of Birth: ____/____/____ Age: ____ Sex: M F

Home Email Address: _____

Employer: _____ Employer Phone: () _____

Social Security No.: ____/____/____ Marital Status: Married Single Divorced Widowed

Spouse: _____ SS#: ____/____/____ Date of Birth: ____/____/____

Nearest Relative: _____ Address: _____ Phone #: () _____

Primary Care Physician: _____ Phone #: () _____

Allergies: _____ Height: _____ Weight: _____

REFERRAL INFORMATION

Referring Physician: _____ Phone #: () _____

Address: _____

INSURANCE INFORMATION *(If you have insurance, please answer the questions below.)*

Name of Primary Insurance Company: _____

Insured's Name: _____ SS#: ____/____/____ Date of Birth: ____/____/____

Does this insurance company require a referral from a primary care physician?: Yes No Copay? \$ _____

If Yes, was this obtained?: Yes No

Name of Secondary Insurance Company: _____

Insured's Name: _____ Date of Birth: ____/____/____

Does this insurance company require a referral from a primary care physician?: _____ Yes No

Copay? \$ _____ If Yes, was this obtained?: Yes No

IMPORTANT INFORMATION

PLEASE READ CAREFULLY: All charges or co-payments, if applicable, are due at the time of services. All professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage unless the services are covered under a contractual agreement between this Medical Practice and your insurance carrier.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Vascular Surgical Associates P.C. or its physicians to release any information acquired in the course of my examination or treatment to: (Insurance Company or Attorney). A copy of this authorization shall be considered as valid as an original.

I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration and Health Care Financing Administration or to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to either myself or to the party who accepts assignment. I understand that I am responsible for any amount not covered by my insurance.

Signature: _____

Date: _____