Dr. Hesham Fakhri, M.D.
Tel: 813-708-VEIN (8346)
Fax: 866-270-9831

PATIENT REGISTRATION

Date_________________ New Pt ___ Estab. Pt ___

NAME ___________________________________ Soc. Sec. _________________________ M __ F __

Date of Birth ____/____/______ Marital Status _____ Race___________________________________
Ethnicity _______________________________
ADDRESS ____
CITY ______________________________ STATE ______________ ZIP ________________
Home Phone ___________________ Cell Phone _____________________
E-mail ____

Occupation: ___________________________ Employer: _________________________
Address _______________________________ City ___________ State_____ Zip _______
Work Phone __________________________ Alt. Phone ____________________________

Spouse/Parent (if applicable) ____
Address ____
Phone _______________________ Alt. Phone __________________________________

Referred By ____
Other physicians who care for you (Primary Care Physician) ______________________________

EMERGENCY CONTACT ____
Relationship __________________________ Phone ______________________________
Address ____

Preferred **Pharmacy** Name and Phone_______________________________________

Preferred form of contact ___ e-mail ___ Phone

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date ______________________ Signature____

I hereby authorize Vein,Heart and Vascular Institute to apply for benefits on my behalf for covered services rendered.
I request that payment from my insurance company(s) be made payable to Vein, Heart and Vascular Institute or to the
party who accepts assignment. I certify the information I have provided with regard to my insurance is correct.

Date ______________________ Signature _______________________________________

I understand that it is my responsibility to understand and know what my insurance will and will not pay for and that I am financially responsible for all non-covered services at the time services are rendered.
I am also responsible for all co-pays and deductibles at the time services are rendered.

Date _______________________ Signature _____________________________________