PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please Print)

Name:_____Today's Date:___/___/____
Last First MI

Preferred Name:_____ Driver's License #:_____

Date of Birth:____/____/_____ Social Security #_____-____-_____

Gender: Male or Female Marital Status: Single / Married / Divorced / Separated / Widow

Address:_____
Street City State Zip Code

Home Phone: (____)_____ Cell Phone: (_____)_____Work Phone: (____)_____

Preferred Method of Contact (Please circle one):

Home Phone Cell Phone Work Phone Email

Is it OK to leave a detailed message on your voice mail? Yes or No

If so messages maybe left on (circle all that apply) Home / Cell / Work

Messages maybe be left for me with (Please list names of those who we can leave a message with):

_____

Is it OK to send text messages regarding appointments? Yes or No

Is it OK to communicate through email? Yes or No

Personal Email Address:_____

Race (Please circle one): American Indian/Alaskan Native Asian Black/African American

Native Hawaiian/Pacific Islander White/Caucasian Unknown

Ethnicity (Please circle one): Hispanic of Latino Not Hispanic or Latino Decline to specify

Preferred Language: _____

Patient Employment Information

Employment Status: Employed Student Self-employed Retired

Employer's Name:_____ Occupation:_____

Pharmacy Information

Pharmacy Name:_____ Phone number: (____)_____
Pharmacy address:_____

Emergency Contact Information

Emergency Contact:_____Relationship:_____Phone #(____)_____

Would you like your medical information released to any family member? Yes No

If yes, whom?_____Relationship to you:_____Phone #(____)_____

How Did You Hear About Us?
Newspaper Ad / Yellow Pages / Insurance Carrier / Internet / Exterior Signage /

Friend or Family / Physician_____ / Other:_____

Physician
PCP Name:_____ OBGYN Name:_____

Phone # (_____)_____ Phone# (____)_____

Insurance Information:
(Please present your current insurance card at time of check in).

Primary Insurance:_____ Policy ID#_____

Group #_____ Insurance Phone #_____

Policy Holder (If not patient): _____

Policy Holder's SSN:_____ Policy Holder's Date of Birth: _____

Secondary Insurance:_____ Policy ID#_____

Group #_____ Insurance Phone #_____

Policy Holder (If not patient): _____

Policy Holder's SSN:_____ Policy Holder's Date of Birth: _____

I understand that I am responsible for all fees regardless of insurance coverage, and that charges are due at time of service unless other arrangements have been made in advance of treatment. If Goldman Vein Institute does bill my insurance, I authorize them to release any or all of my medical records to my insurance companies for assigned payment of medical benefits. Consent is hereby given to the treating physician to administer treatment and to perform such medical and/or surgical procedures that are deemed necessary for treatment. I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time.

Patient (Print Name):_____

Patient (Signature):_____Date:_____