



610 South Maple, Suite 2800
 Oak Park, Illinois 60304
 Office (312) 563-4120 • Fax (312) 563-4127

PATIENT REGISTRATION

PATIENT NAME			DATE OF BIRTH	
HOME ADDRESS		CITY	STATE	ZIP CODE
SOCIAL SECURITY NUMBER	AGE	SEX	HOME PHONE	WORK PHONE
EMPLOYER		JOB TITLE		
EMERGENCY CONTACT		HOME PHONE	WORK PHONE	
PRIMARY CARE PHYSICIAN		OFFICE TELEPHONE NUMBER		
REFERRING PHYSICIAN		OFFICE TELEPHONE NUMBER		

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	VERIFICATION TELEPHONE

SECONDARY INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	VERIFICATION TELEPHONE

HOW DID YOU HEAR ABOUT US?	<input type="checkbox"/>	Primary Care Physician	<input type="checkbox"/>	Newspaper / Magazine Ad	<input type="checkbox"/>	Family / Friend	<input type="checkbox"/>	Other
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PATIENT AUTHORIZATION

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT FOR SERVICES:

I hereby authorize payment directly to The Vein Care & Vascular Center benefits due me for services described herein. I understand and agree that I am financially responsible for charges not paid by my insurance policy. If my account is referred to collection, I will be responsible for reasonable attorney's fees and collection costs.

AUTHORIZATION TO RELEASE MEDICAL RECORDS:

I hereby authorize The Vein Care & Vascular Center to release medical information to other providers participating in my care and as it relates to and as needed basis for other physician consultants. In addition, I authorize other providers participating in my care to provide copies of medical records to The Vein Care & Vascular Center on an as needed basis.

This authorization and payment agreement is made in Cook County, Illinois

 Patient Date Insured or Responsible Party other than Patient Date