Patient Information

Last Name ______________________________ First ____________ Middle ____________________

DOB __________ Sex __________ SSN ____________________ e-mail ____________________

Primary Address ______________________________ City __________ State ______ Zip ______
Mail Address
(if different than primary address) ____________________ City __________ State ______ Zip ______

Home Phone ______________________________ Other Phone ______________________________

Primary Care Physician ____________________________ Phone ______________________________

Referring Physician ______________________________ Phone ______________________________

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Employment Status: Full Time ☐ Part Time ☐ Student ☐ Unemployed ☐ Homemaker ☐

Emergency Contact Information

Name ______________________________ Phone ______________ Relationship ________________

Insurance Information

Primary Insurance ____________________ Policy # ____________________ Group # ________________

Policy Holder Name __________________________ Holder's DOB ______________ Sex ____________

Employer ______________________ Emp. Address ________________ Emp. Phone ________________

Relationship to Insured: Spouse ☐ Child ☐ Other ☐ Phone ______________________________

Secondary Insurance __________________ Policy # ____________________ Group # ________________

Policy Holder Name __________________________ Holder's DOB ______________ Sex ____________

Employer ______________________ Emp. Address ________________ Emp. Phone ________________

Relationship to Insured: Spouse ☐ Child ☐ Other ☐ Phone ______________________________

Authorization for Release of Information: I authorize 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 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 or health plan administrator to release such information to Vanishing Veins.

Assignment of Benefits: I request that payment of authorized insurance benefits to 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.

I hereby acknowledge that I am personally responsible for the cost of all procedures provided by Vanishing Veins. I understand that Vanishing Veins will make reasonable efforts to collect payment from my medical insurance provider, however, in the event that an insurance company denies payment or only makes a partial payment; I agree to be responsible for the full amount of billed charges or any remaining balance that may be due. I agree to pay Vanishing Veins any amounts due within 15 days of receiving an invoice.

Patient/Guardian Signature: ______________________________________ Date: ____________________