Vascular Specialty Center

The leading-edge care, capabilities & experience doctors trust.

Patient Registration Form

(Please print and return to front desk)

Patient Information

Name:
Last First MI

c/o Name, if patient is a minor:

Address:

City: **State:** **Zip:**

Home Phone: **Cell:** **Work:**

Primary Insurance: **Secondary Insurance:**

Primary Care or Referring Doctor: **Driver's License Number:**

Social Security Number: **[ ] Male [ ] Female** **Date of Birth: / /**

Race: [ ] Black or African American [ ] American Indian or Alaska Native [ ] Asian [ ] White [ ] Hispanic [ ] Pacific Islander [ ] Native Hawaiian or other [ ] Refused to answer

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Refused to Answer

Language: [ ] English [ ] Spanish [ ] Other [ ] Refused to Anser

Place of Employment/School: [ ] Full [ ] Part

Employer Address:
Street State Zip

Emergency Contact:
(phone number different from your own) Name Phone Number

Authorization

I, the undersigned, authorize the release of any medical or insurance information to the stated insurance company necessary to process insurance claims for services rendered by the facility. I hereby authorize Vascular Specialty Center and Vascular Specialty Laboratory, Inc. to distribute the payment of my (or my dependents) medical coverage directly to the provider rendering services. I understand that I am full responsible for all charges regardless of my insurance benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____

Date: _____