PATIENT REGISTRATION

Patient Information

Name: ______________________ DOB: ______________

c/o Name, if patient is a minor: ______________________

____
street

____
city *state* *zip code*

____
cell #

____
home #

____
work #

Preferred contact: ☐ *cell* ☐ *home* ☐ *work*

____
e-mail

SSN: ______________ DL#: ______________ ☐ Male ☐ Female

Employment/School: ______________________ ☐ Full ☐ Part

Race

- ☐ African or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Pacific Islander
- ☐ White
- ☐ Native Hawaiian
- ☐ Hispanic
- ☐ Refuse to answer
- ☐ Other ______________

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refuse to Answer

Language

- ☐ English
- ☐ Spanish
- ☐ Other ______________
- ☐ Refuse to answer

How did you hear about us? ______________________

Insurance & Medical Release

Person for release of medical information: ______________________
name *phone number*

To decline, sign here: ______________ **without designated member listed, we cannot release your information to them.*

Primary Insurance: ______________________ Referring Dr. : ______________

Secondary Insurance: ______________________ Primary Dr. : ______________

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 fully responsible for all charges regardless of my insurance benefits. I authorize the use of this signature on all insurance submissions.

Signature: ______________________ Date: ______________