Patient Demographic Form

LAST _____ FIRST _____ MI _____ Nickname _____

ADDRESS _____ CITY, STATE, ZIP _____

HOME NUMBER _____ WORK NUMBER _____ CELL NUMBER _____

PREFERRED CONTACT? (please circle one)
HOME | WORK | CELL

I AUTHORIZE VVC TO CONTACT ME AND/OR LEAVE MESSAGES AT THE DESIGNATED PRIMARY PHONE NUMBER _____ (initials)

M / F DOB _____ PROFESSION _____ EMAIL _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

MARITAL STATUS _____ SPOUSE NAME & NUMBER _____
(if different from above)

INSURANCE INFORMATION

INSURANCE COMPANY NAME _____

MEMBER NUMBER _____ GROUP NUMBER _____ EMPLOYER _____

ADDRESS _____ PHONE NUMBER _____
(the above information is located on the back of the card)

POLICY HOLDER'S NAME _____ DOB _____ SS# _____

POLICY HOLDER'S PHONE _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE COMPANY NAME _____

MEMBER NUMBER _____ GROUP NUMBER _____ EMPLOYER _____

ADDRESS _____ PHONE NUMBER _____
(the above information is located on the back of the card)

POLICY HOLDER'S NAME _____ DOB _____ SS# _____

POLICY HOLDER'S PHONE _____ RELATIONSHIP TO PATIENT _____

AUTHORIZATIONS:

I authorize Vincent Vein Center to release any information necessary to process insurance claims. I authorize Vincent Vein Center to appeal any denials of insurance coverage on my behalf. I authorize payment of benefits directly to Vincent Vein Center. I understand that I am responsible for copays, co-insurance, and any non-covered services and claims denied by insurance, and agree to pay any and all costs of collection including attorney fees and court costs.

Patient signature _____ Date _____

For tracking purposes, we'd like to know how you learned about Vincent Vein Center.

(please check all that apply)

- ☐ TV COMMERCIAL
- ☐ INTERNET SEARCH
- ☐ RADIO ADVERTISEMENT
- ☐ NEWSPAPER
- ☐ BILLBOARD
- ☐ COMMUNITY EVENT
- ☐ GV MAGAZINE
- ☐ PHONE BOOK
- ☐ FRIEND OR RELATIVE
- ☐ PHYSICIAN REFERRAL _____
- ☐ OTHER (specify) _____