

VEIN SPECIALISTS OF NORTHWEST GEORGIA VASCULAR SURGICAL ASSOCIATES, P.C.

(Please Print)

Date: ____/____/____ Chart No.: _____ Employee Initial: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State / Zip: _____

Home Phone: () _____ Cell/Pager: () _____ Date of Birth: ____/____/____ Age: ____ Sex: M F

Home Email Address: _____

Social Security No.: ____/____/____ Marital Status: Married Single Divorced Widowed

Race: _____ Ethnicity: _____ Preferred Language: _____

Spouse: _____ SS#: ____/____/____ Date of Birth: ____/____/____

Emergency Contact: _____ Address: _____ Phone #: () _____

Employer: _____ Employer Phone: () _____

HOW DID YOU HEAR ABOUT US? Magazine _____ Radio _____ Doctor Referral: _____

Referring Physician: _____ Phone #: () _____

Primary Care Physician: _____ Phone #: () _____

Traditionally, we have mailed reminders to patients who need to schedule appointments for periodic follow-up. We now offer alternative means of reminding you to schedule an appointment. Please specify your preference: Mail ____ Phone ____

INSURANCE INFORMATION (If you have insurance, please answer the questions below.)

Do you have a Health Savings or Reimbursement Account? Yes No

Name of Primary Insurance Company: _____

Insured's Name: _____ SS#: ____/____/____ Date of Birth: ____/____/____

Member Number: _____ Group Number: _____

Does this insurance company require a referral from a primary care physician? Yes No Co-pay? \$_____

If Yes, was this obtained?: Yes No

Name of Secondary Insurance Company: _____

Insured's Name: _____ SS#: ____/____/____ Date of Birth: ____/____/____

Member Number: _____ Group Number: _____

Does this insurance company require a referral from a primary care physician? Yes No Co-pay? \$_____

If Yes, was this obtained?: Yes No

AUTHORIZATION, RELEASE, AND FINANCIAL RESPONSIBILITY: I hereby authorize Vascular Surgical Associates P.C. or its representatives to release any information acquired in the course of my examination or treatment to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, workers' compensation carriers, adjusters or attorneys. I instruct and direct my insurance carrier(s) to pay Vascular Surgical Associates, PC, by check or electronic remittance for services billed to them on my behalf. I agree to pay any portion determined my responsibility by my insurance carrier including but not limited to co-payments, deductibles, and non-covered services. I assume full financial responsibility for services not covered by insurance.

I authorize representatives of Vascular Surgical Associates to discuss or otherwise share information regarding my condition and treatment with the individuals listed below. This authorization may be revoked at any time.

Name	Relationship	Name	Relationship
1) _____	_____	3) _____	_____
2) _____	_____	4) _____	_____

I understand that Vascular Surgical Associates utilizes Physician's Assistants for levels of practice approved by the state medical board. I understand and agree to receive services provided by such providers when necessary and appropriate.

A photocopy of this document shall be considered as valid as the original. The undersigned certifies that he/she understands and agrees to the terms outlined above.

Signature: _____ Date: _____