

# Patient Registration Form

(Please print and return to front desk)

Patient Information

Name	Last	First	MI	
c/o Name	Last	First	MI	
Address	Street	City	State	Zip
Telephone Number	Home ( ) -	Work ( ) -	Cell ( ) -	Pager ( ) -
Provider				
Referred By	Driver's License #			
Social Security Number	-	-	Date Of Birth	/ /
Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Place of Employment/School	Name	<input type="checkbox"/> Full <input type="checkbox"/> Part		
Employer Address	Street	City	State	Zip
Emergency Contact	Name	Phone # ( ) -	(phone number different than your own)	

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 this facility. I hereby authorize Vascular Surgery Associates and Vascular Associates Lab, 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: \_\_\_\_\_