

**THE VEIN CLINIC, INC.**  
PATIENT REGISTRATION

**YEAR** \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

SINGLE     MARRIED     OTHER

SEX:     MALE     FEMALE

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

EMPLOYER/SCHOOL NAME & ADDRESS:  
\_\_\_\_\_  
\_\_\_\_\_

**INSURANCE INFORMATION:**

**PRIMARY INSURANCE**

INSURANCE NAME: \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_

POLICY HOLDER'S SSN: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

POLICY HOLDER'S SEX:     MALE     FEMALE

POLICY HOLDER'S DATE OF BIRTH: \_\_\_\_\_

**SECONDARY INSURANCE**

INSURANCE NAME: \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_

POLICY HOLDER'S SSN: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

POLICY HOLDER'S SEX:     MALE     FEMALE

POLICY HOLDER'S DATE OF BIRTH: \_\_\_\_\_

ACCOUNT #: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

WHAT ARE YOU BEING SEEN FOR?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ANY FOOD OR DRUG ALLERGIES?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HOW WERE YOU REFERRED TO  
OUR OFFICE?**

DOCTOR                       CO-WORKER

RELATIVE                       WALK-IN

TV COMMERCIAL     INS. PROVIDER BOOK

NEWSPAPER AD, which one? \_\_\_\_\_

OTHER: \_\_\_\_\_

IN CASE OF EMERGENCY,  
NAME & PHONE NUMBER OF  
NEAREST RELATIVE:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize this physician to release any information required in the course of my examination or treatment to my insurance company and/or to any other provider.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

**AUTHORIZATION TO PAY:** I hereby authorize payment directly to the business of this physician for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_