Reincke Vein center

PATIENT INFORMATION

Name: _____
Last Name First Name M.I.

Mailing Address:_____
Street City State Zip

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Date of Birth:_____/_____/_____ Age:_____ Sex:_____ SS#:_____

Marital Status: ☐ Single ☐ Married Occupation:_____

Race:_____ Primary Language:_____Ethnicity:_____

Email Address:_____

Where you referred by your doctor: ☐ Yes ☐ No Referring Doctor Name:_____

If not, how did you hear about us?

☐ TV	☐ Brochure	☐ Google
☐ Radio	☐ Online Ad	☐ Friend/Family: _____
☐ Newspaper	☐ Facebook	☐ Other:_____

Primary Care Physician: _____ Phone: (_____)_____

Address: _____
Street City State Zip

Pharmacy of Choice: _____ Phone: (_____)_____

Address: _____
Street City State Zip

In an emergency, who should be notified? _____ Phone: (_____)_____

Other family members that are patients:_____

Responsible Party (If different from patient):

Name: _____
Last Name First Name M.I.

Mailing Address:_____
Street City State Zip

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Date of Birth:_____/_____/_____ Age:_____ Sex:_____ SS#:_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

_____
Patient or Responsible Party Signature Date