

## Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: F M

Preferred Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Contact #s Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse name: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_

Relation to patient: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Referring physician (if any): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Primary care physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

## Health Insurance Information

Primary Insurance: \_\_\_\_\_ State: \_\_\_\_\_ Policy # \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ State: \_\_\_\_\_ Policy \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Other Insurance: \_\_\_\_\_ State: \_\_\_\_\_ Policy \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

<p><i>How did you hear of our practice?</i> <input type="checkbox"/> Referring Doctor <input type="checkbox"/> Friend/Family Member <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Newspaper _____ <input type="checkbox"/> SJMH Employee <input type="checkbox"/> Magazine <input type="checkbox"/> Other</p>
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**Authorization** (for Medicare, Priority Health, HAP, Blue Care Network, and Blue Cross/Blue Shield plans)  
I hereby authorize my insurance carriers to pay benefits directly to Restoration Vein Care, PLC. I understand that I am responsible to pay for any services not covered by my insurance. I also authorize release of pertinent medical information to my insurances carriers and the above-named physicians.

\_\_\_\_\_  
Signature Date