

Vein & Vascular Center of South Florida

www.floridavascul.com

REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name			First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status		
<input type="checkbox"/> Yes <input type="checkbox"/> No			If not, what is your legal name?		Social Security		Birth Date	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address			<input type="checkbox"/> Home	<input type="checkbox"/> Apt	City	Zip	Zip	Home Phone No. ()	
Occupation		Employer				Employer Phone No. ()		Cell Phone No. ()	
Religion		Primary Language Spoken			Email Address				
Primary Care Doctor			Phone No. ()			Phone No. ()			
Referred to office by (Please check one box) <u> </u> Dr.									
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to Home/Work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Hospital <input type="checkbox"/> Other _____									
Other Family Members Seen Here _____									
Reason for today's visit? _____									

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

PRIMARY	SECONDARY
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IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ()	Work Phone No. ()
Street Address	City	State	ZIP Code

GUARANTEE OF PAYMENT:

- I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to the physician's office.

AUTHORIZATION TO RELEASE INFORMATION:

- I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

ASSIGNMENT OF INSURANCE BENEFITS:

- If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the Physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in place of the original.

MEDICARE AUTHORIZATION:

- I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment, I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.A.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to medical assignment of benefits also apply.

X _____
 PATIENT/GUARDIAN SIGNATURE DATE