

THE VEIN AND VASCULAR TREATMENT CENTERS* ("VVTC")

REGISTRATION FORM

Please complete the following - PLEASE PRINT.

PATIENT INFORMATION:

Today's Date: _____

Name: _____ Home Phone: _____
Last Name First Name Initial

Address: _____
Street City State Zip

Sex: F ___ M ___ Age: _____ Birthdate: _____ Soc.Sec.#: _____

Patient Employed by: _____ Business Phone: _____

Business Address: _____
Street City State Zip

In case of emergency who should be notified? _____
Name Phone

PRIMARY INSURANCE

Person Responsible for Account: _____
Last Name First Name Initial

Relationship to Patient: _____ Birthdate: _____ Soc.Sec.#: _____

Address (if different from patient's): _____
Street City State Zip

Home Phone (if different from patient's): _____

Person Responsible Employed by: _____ Business Phone: _____

Business Address: _____
Street City State Zip

Insurance Company: _____

Subscriber #: _____ Group #: _____

* a division of GREAT LAKES RADIOLOGISTS, S.C.

SECONDARY INSURANCE

Is patient covered by other insurance? Yes ___ No ___

If yes, Subscriber's Name: _____
Last Name *First Name* *Initial*

Relation to Patient: _____ Birthdate: _____ Soc.Sec.#: _____

Address (if different from patient's): _____
Street *City* *State* *Zip*

Home Phone (if different from patient's): _____

AUTHORIZATION

By signing this form below I am granting permission to VVTC to use and or disclose my health information to others for the purpose of receiving payment for treatment and services that I may receive. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ Date: _____
Signature of Patient or Personal Representative

If Personal Representative, describe relationship: _____