Patient Registration Form

Patient Information

Name: _____Date: _____

Address: _____City: _____State: _____Zip: _____

Home Phone: _____Cell Phone: _____Email: _____

Nickname: _____SSN#: _____ Date of Birth: _____

Marital Status: _____Emergency Contact: _____(Phone)_____

Occupation: _____Employer: _____Work Phone: _____

Primary Care Provider: _____Referring Provider: _____

Demographic Information

Preferred Language (Circle One) English Spanish Other _____ Religious Affiliation _____

Ethnicity (Circle One) Hispanic or Latino Not Hispanic or Latino Unknown

Race (Circle) Caucasian Black or African American Asian Hispanic or Latino American Indian Alaskan Native Native Hawaiian or Other Pacific

Insurance Information

Primary Insurance: _____Phone: _____

Policy Holder Name: _____Relationship: _____

Policy Holder Date of Birth: _____SSN#: _____

Policy ID# or Member ID #: _____ Group #: _____

Referral Information

How did you hear about our office? (Circle One)

Physician: _____ Brochure in the Mail Online Friend/Family Member Sign

Medications Please list all prescribed or over the counter medications you are currently taking.

_____

_____

Allergies Please list all drug and/or food related allergies.

_____

_____

The above information is true to the best of my knowledge. I authorize Vascular Institute of the Pines to file insurance claims on my behalf, and payment of those claims to be made directly to Vascular Institute of the Pines. I authorize Vascular Institute of the Pines to release any information necessary to process my claim information. I understand that any balance unpaid by my insurance company is my responsibility.

Patient/Guardian Signature: _____Date: _____