TRUFFLES VEIN SPECIALISTS

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Social Security no.:	Preferred Name:	Email Address:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Mobile phone no.: ( )	Home phone no.: ( )

City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred by or heard about us from: ❑ Dr. ____________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Drive by ❑ MediSpa ❑ Advanced ❑ Other : ______________________________

You agree you are here for a Consultation, which your insurance will be billed for your visit. Initial here: ________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Policy no.: (If card not present)

Is this person a patient here? ☐ Yes ☐ No

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.: (If card not present)

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize truffles vein specialists or insurance company to release any information required to process my claims.

_____________________________________ _____________________

Patient/Guardian signature *Date*