MequonVein

Patient Demographics

Patient's Name: _____ _____ _____
Last *First* *M.I.*

DOB: _____/_____/_____ Sex: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ D ❑ W

Address: _____ City _____ State _____ Zip _____

Please leave only numbers that we may call:

Preferred Phone #: _____ ❑ Cell ❑ Home ❑ Work

Alternate Phone #: _____ ❑ Cell ❑ Home ❑ Work

Email: _____

Employer: _____ Occupation: _____

Employer Address: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Primary Care Physician: _____ Phone: _____

Address: _____ May we contact? ❑ Y ❑ N

OB/GYN Physician: _____ Phone: _____

Address: _____ May we contact? ❑ Y ❑ N

How did you hear about us? ❑ Family _____ ❑ Friend _____

❑ Physician (Name & Location) _____ May we contact? ❑ Y ❑ N

❑ Fair Event ❑ Magazine ❑ Website ❑ Newspaper ❑ Other _____

Insurance Information

Primary Insurance Information

Policyholder Name: _____ _____ _____
Last *First* *M.I.*

Relationship: ❑ Self ❑ Spouse ❑ Other _____

Policy Holder DOB _____/_____/_____

Insurance Company: _____

Policy/ID #: _____ Group #: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Secondary Insurance Information

Policyholder Name: _____ _____ _____
Last *First* *M.I.*

Relationship: ❑ Self ❑ Spouse ❑ Other _____

Policy Holder DOB _____/_____/_____

Insurance Company: _____

Policy/ID #: _____ Group #: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

ASSIGNMENT OF BENEFITS:

I hereby authorize payment directly to Mequon Vascular Associates, SC for all services rendered. I hereby authorize Mequon Vascular Associates, SC to release any information required to determine medical benefits payable for services to the organization, my insurance carrier or other medical entity. I understand that I am financially responsible to the organization for any charges not covered by my health care benefits. It is my responsibility to notify Mequon Vascular Associates, SC of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Signed: _____ **Date:** _____