

# Patient Registration Form

(Please print and return to front desk)

<b>Patient Information</b>	Name	Last	First	MI
	c/o Name	Last	First	MI
	Address	Street	City	State Zip
	Telephone Number	Home ( ) -	Work ( ) -	
		Cell ( ) -	Pager ( ) -	
	Provider			
	Primary Care or Referring Dr:	Driver's License #		
	Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date Of Birth	/ /
	Race:	<input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian American <input type="checkbox"/> Hispanic <input type="checkbox"/> Multiracial <input type="checkbox"/> Other		
	Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
	Place of Employment/School	Name	<input type="checkbox"/> Full <input type="checkbox"/> Part	
	Employer Address	Street	City	State Zip
Emergency Contact (phone number different than your own)	Name	Phone # ( ) -		

<b>Authorization</b>	<p>I, the undersigned, authorize the release of any medical or insurance information to the stated insurance company necessary to process insurance claims for services rendered by this facility. There will be a charge for required ultrasounds after the <b>Initial Free Consultation</b>. I hereby authorize <b><u>TOTAL VEIN CARE</u></b> to distribute the payment of my (or my dependents) medical coverage directly to the provider rendering services. I understand that I am fully responsible for all charges regardless of my insurance benefits. I authorize the use of this signature on all insurance submissions.</p>
	<p>Signature: _____</p> <p>Date: _____</p>