

Alabama & Atlanta Vascular and Vein Patient Registration Form

Please confirm the following information:

First Name _____ MI _____ Last Name _____

Home Phone# _____

Work Phone# _____

Cell Phone# _____

e-mail _____

Please indicate by placing a 1, 2, or 3 next to each phone number to indicate the order in which you would like us to contact you to confirm your appointments.

It is o.k. to contact me at work.

It is o.k. to contact me after normal business hours.

Tell us what kind of work you do by completing the following sentence:

I work as a/an. . . . _____

(If you are retired, tell us what kind of work you did before retirement.)

Date of Birth: _____ / _____ / _____

Gender: Male Female (circle one)

Home Address: _____ SSN: _____ - _____ - _____

City, State, Zip: _____

Name of Person to contact in an Emergency: _____

Their Phone#: _____ - _____ - _____ Your relationship: _____

Whom may we thank for referring you to our practice, or how did you learn about our services? _____

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Insurance Information:

Please provide our receptionist with your Drivers License
and your primary insurance card
(and secondary insurance card if you have secondary insurance)
so we may make a copy of these cards and keep them in your file.

Please complete the following information, then sign and date below:

Name of Primary Insurance Company: _____

Is the above Primary Insurance Policy in your name? Yes No

If the above primary insurance policy is **NOT** in your name, please provide the following information:

Name of the Policy Holder: _____

Social Security # of the Policy Holder: _____

Date of Birth of the Policy Holder: _____

Your Relationship to the Policy Holder: _____

Name of Secondary Insurance Company: _____

Is the above Secondary Insurance Policy in your name? Yes No

If the above secondary insurance policy is **NOT** in your name, please provide the following information:

Name of the Policy Holder: _____

Social Security # of the Policy Holder: _____

Date of Birth of the Policy Holder: _____

Your Relationship to the Policy Holder: _____

Authorization: I authorize the release of medical information necessary to process this claim or provide medical information to my insurance carriers, or to any physician or medical facility. I authorize payment of medical benefits to Alabama and Atlanta Vascular and Vein for all professional goods and services rendered. I understand I am financially responsible for any charges whether or not covered by insurance.

Patient Signature: _____ Date: _____

Patient Name: _____

Date: _____