SAN FRANCISCO VEIN & VASCULAR INSTITUTE

A BASS MEDICAL GROUP AFFILIATE

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PATIENT REGISTRATION FORM

Name: _____, _____ Date of Birth_____/_____/_____
(Last Name) (First Name)

Address: _____
(Street) (Apt #) (City) (State) (Zip Code)

Home #: _____ Cell #: _____ Fax #.:_____

Email: _____

Social Security #: _____-_____-_____ Drivers License #: _____ Gender: _____

Marital Status: _____ Occupation: _____ Work No.: _____

Employer: _____ Employer Fax No.: _____

Emergency Contact: _____
(Name) (Relation) (Number)

Primary Care Physician: _____

Nephrologist: _____ Cardiologist: _____

Dialysis Location _____ Dialysis Date(s) _____

PRIMARY INSURANCE:

Insurance Company: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Relationship to Subscriber: _____

SECONDARY INSURANCE:

Insurance Company: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Relationship to Subscriber: _____

WORKER'S COMPENS ATION

Is this work-related? □ No □ Yes If yes, date of injury? _____ Claim No.#: _____

Spouse's Name: _____ SS No.#: _____

PLEASE PRESENT ALL OF YOUR INSURANCE CARDS & PHOTO I.D. TO FRONT DESK SO WE MAY PLACE A COPY IN YOUR CHART

As a member of your health plan, you are required to pay the co-pay amount listed on your insurance card, unless it is a post operative encounter within 90 days of your date of surgery. If you are a new patient and or are here for a follow-up with one of our Vascular Physicians, your co-pay due at time of visit. Our office accepts, Cash, Check, and/or Credit Cards (Visa, Master Card, Discover, and ATM/DEBIT) As a patient of San Francisco Vein & Vascular Institute, I attest that the information above is true to the best of my knowledge. I fully understand that I am responsible for any indebt-ness by my dependents or myself. I give permission to San Francisco Vein & Vascular Institute to bill my insurance company and have the payment sent directly to the Institute. I will be responsible for any residual fees not covered by my medical insurance carrier. Difficulties that occur are to be dealt with by my insurance carrier and myself. I authorize information to be shared with a third party for billing purpose. I authorize the San Francisco Vein & Vascular Institute to share my medical information with other medical providers as deemed necessary for my care.

_____ _____

(Signature) **(Date)**