FOX VALLEY VEIN CENTERS

Patient Name:_____ SS#:_____

Address:_____ Home Phone:_____

City, State, Zip:_____ Cell Phone:_____

DOB:_____ Work Phone:_____

Marital Status (Circle One): Married Single Divorced Separated Widowed

Email:_____ Would you like to receive our monthly newsletter? Yes No

How do you prefer your appointments be confirmed? (Circle One): Home Phone Cell Phone Email Text

Employer:_____

Address:_____ City, State, Zip:_____

How did you hear about us (Circle One): Billboard Clipper Ad Family Friend Health Dept. Hospital (Rush-Copley, Valley West, Edward) Insurance Company Internet Newspaper Postcard Radio Phone Book Physician Other

EMERGENCY CONTACT

Name:_____ Relationship:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

INSURANCE INFORMATION

Primary Insurance Co._____ Policy Holder:_____

DOB of Policy Holder:_____ Employer:_____

ID#:_____ Group #:_____ Copay $:_____

Secondary Insurance Co._____ Policy Holder:_____

DOB of Policy Holder:_____ Employer:_____

ID#:_____ Group #:_____ Copay $:_____

Primary Care Physician:_____ Office Phone:_____

RELEASE AND FINANCIAL CONSENT

I hereby authorize the physicians at Fox Valley Vein Centers, PC and staff under their direction to release all medical information, including test results, regarding my condition and medical treatment, to my primary care physician and/or insurance company. I understand that I am financially responsible for all medical charges, whether or not paid by insurance, and I hereby authorize that use of this signature on all insurance submission.

Patient Signature:_____ Date:_____