MequonVein

Patient Demographics

Patient's Name: ______________________ ______________________ ______
Last First M.I.

DOB: ____/____/____ SS#:____________ 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 ____/____/____ SS# ____________

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 ____/____/____ SS# ____________

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:** ____________