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**VASCULAR ASSOCIATES  
OF CONNECTICUT, L.L.C.**

Patient Name: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_  
(Please print) Last First M  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Were X-Rays/ CT Scans/ Ultrasound taken? \_\_\_\_\_  
If yes, when / where were the tests done? \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Carrier: \_\_\_\_\_ Secondary Carrier: \_\_\_\_\_

Identification Number: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Group Name/ Number: \_\_\_\_\_ Group Name/Number: \_\_\_\_\_

SS Number of Insured: \_\_\_\_\_ SS Number of Insured: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

***Insurance Authorization and Assignment***

*I request that Payment of Authorized Medicare/ Other Insurance Company benefits be made to either me or on my behalf to Connecticut Vein Care for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying in my treatment.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_