Connecticut Vein Care

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:* ___________________