Patient Registration Form

The Vein Treatment Center ~ Dr. William P. Kalchoff and Dr. Grady L. Hallman

Name: ____ DOB: _______________ Age: ______ Sex M/F

SS number: _________________________________ Email: ______________________________________

Address: ____

City: ______________________________________ State: ________ Zip code: ______________________

Tel home: _______________________Cell: ______________________ Work: _______________________

Social Status: Married Single Separated Divorced Widowed

Emergency Contact: __________________________________ Number: __________________________

Occupation: ____________________________Employer: ____

Employer Address: ____

How did you hear about us? ____

Primary Insurance

Person responsible for account: ____

Relation to patient: ____________________ Date of Birth _________ SS number: _________________

Group number ______________________________ Subscriber Number __________________________

Secondary Insurance

Person responsible for account: ____

Relation to patient: ____________________ Date of Birth _________ SS number: _________________

Group number ______________________________ Subscriber Number __________________________

I certify that I and / or my dependent(s) have insurance coverage with ___________________________________ and assign to The Vein Treatment Center all the insurance benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I authorize that use of my signature on all insurance submissions. The Vein Treatment Center may use my health information and disclose such information to my insurance company and their agents for the purpose of obtaining payment for services, benefits or benefits payable to services. This consent will end when my current treatment plan is completed or one year from the date signature hereunder.
I request payment under the Medicare program that may have to be made to The Vein Treatment for services rendered.

Patient Signature: _____________________________________ Date: ___________________________