NEW PATIENT INFORMATION

Patient Name (Last, First, Middle Initial)	Birthdate	Sex	Marital Status	Account#

Patient Address (City, State, Zip)	**Work Phone** ( )	**Home Phone** ( )
Patient Employer	**Social Security Number**	**Cell Phone Number:**
Guarantor Name (If different than Patient)	**Guarantor Address** (If different than Pt)	**Guarantor Phone** (If different than Pt)
Emergency Contact (Last, First, MI)	**Insured Employer**	**Guarantor Work Phone** (If different than Pt)
Emergency Home Phone ( )	**Emergency Work Phone** ( )	**Emergency Address**
Primary Insurance Name **Co-Pay Amount: $**	**Primary Insurance Address (City, State & Zip)**	**Name of Insured (Subscriber)**
Member ID Number	**Primary Insurance Phone Number**	**Date of Birth Insured**
Secondary Insurance Name **Co-Pay Amount: $**	**Secondary Insurance Address (City, State & Zip)**	**Name of Insured (Subscriber)**
Member ID Number	**Secondary Insurance Phone Number**	**Date of Birth Insured**
How did you hear of the clinic? TV, Radio, Newspaper, Mailer, Website, Yellow Pages, Friend/Relative, Other ________________	**Referring Doctor**	**Primary Care Physician**

Authorization to Pay Benefits to Physician: I hereby authorize payment directly to Advanced Vein Care Solutions of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but do not exceed the reasonable and customary charge for those services. I understand the provider's charge may exceed the private insurance carrier payment, and if greater than such payment, I will be responsible for that amount.

Authorization to Release Information: I hereby authorize Advanced Vein Care Solutions to release any information required in the course of my examination or treatment.

I hereby authorize photocopies of this form to be as valid as the original.
I hereby authorize consent for medical treatment.

________________________________ ________________

Signed (patient or parent if minor) **Dated**