VITAL

HEART & VEIN

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: ____ Sex: M F Marital Status: _____

Date of Birth: _____ SSN: _____ Race: _____ Ethnicity: _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone Number: _____ Cell: _____ Work: _____

Primary Physician: _____ Phone Number: _____

Pharmacy Name: _____ Pharmacy Number: _____

Who referred you to Vital Heart & Vein: _____

Purpose of this visit?: _____

PATIENT'S EMPLOYER

Employer: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ Fax Number: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

GUARANTOR INFORMATION

PERSON RESPONSIBLE FOR THE ACCOUNT

Last Name: _____ First Name: _____ M.I.: _____

Date of Birth: _____ SSN: _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone Number: _____ Cell: _____ Work: _____

Relationship: _____ Employer: _____

FAMILY & FRIENDS

PLEASE LIST THE NAMES OF WHOM WE MAY NEED TO SHARE INFORMATION WITH (FAMILY, FRIENDS, OTHER PHYSICIANS, ETC.)

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

VITAL

HEART & VEIN

INSURANCE INFORMATION

Self-pay, no medical insurance coverage (please check): ☐

Name of Primary Insurance: _____ Phone Number: _____

Date of Birth: _____ SSN: _____

Claims Address: _____ City: _____ Zip: _____

Policy ID Number: _____ Group Number: _____

Name of Secondary Insurance: _____ Phone Number: _____

Date of Birth: _____ SSN: _____

Claims Address: _____ City: _____ Zip: _____

Policy ID Number: _____ Group Number: _____

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES INCURRED. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN AND I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT	DATE

ASSIGNMENT OF BENEFITS:

The undersigned hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claim for benefits, for services that will be bound by this signature as though the undersigned had personally signed the claim.

SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT	DATE

CONSENT TO CARE:

I authorize and direct Vital Heart & Vein to perform upon me injections, draw blood, and/or any other procedure or treatments the doctor may in his or her best judgement determine advisable for my well-being.

SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT	DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received a copy of the Notice of Privacy Practices for Vital Heart & Vein. We reserve the right to modify the privacy practices outlined in the notice.

SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT	DATE