Name:_____________________________________ Birthday:________________________________

Address:____________________________________ Social Security No.:________________________

City:_______________________________________ Marital Status: S M D W

State:_______ Zip Code:______________________ Sex: M F

Home Phone:_______________________________ Okay to leave message: Yes or No

Cell Phone:_________________________________ Okay to leave message: Yes or No

E-mail:_____________________________________ Access to your Electronic Records: Yes or No

How did you hear about our practice:____________

Employer:__________________________________ Business Phone:__________________________

Emergency Contact:_________________________ Relation to patient:________________________

Phone:_____________________________________ Okay to leave message? Yes or No

Primary Care Physician:______________________ Phone:__________________________________

Referring Physician:__________________________ Phone:__________________________________

Pharmacy:___________________________________ Phone:__________________________________

Primary Insurance:___________________________ Subscriber Name:_________________________

ID/Certificate No.:___________________________ Group No.:______________________________

Secondary Insurance:_________________________ Subscriber Name:_________________________

ID/Certificate No.:___________________________ Group No.:______________________________

Authorization for Release of Medical information:

I hereby authorize Nelson Vein & Surgical Services to release any medical information including that, which may be required in the processing of insurance forms for services rendered.

Signature: __________________________________ Date:___________________________________

Consent for Medical Examination & Evaluation:

I authorize Nelson Vein & Surgical Services to a physical examination, evaluation and retrieval with review of my medications.

Signature: __________________________________ Date:___________________________________

Assignments of Insurance Benefits:

I authorize direct payments for surgical and medical benefits by my insurance company to Nelson Vein & Surgical Services. I am responsible for any balance remaining after treatments are rendered. I am responsible for any and all co-payments, co-insurance, and any deductible balance that has not been met this year. Precertification/ Predetermination is not a guarantee of payment. If my insurance information is not correct, I am responsible for all remaining balances after services are rendered.

Signature: __________________________________ Date:___________________________________

Authorization of Nelson Vein & Surgical Services as a Training Site

I acknowledge Nelson Vein & Surgical Services as a training facility and understand that physicians may be observing in the room while Dr. Nelson performs the procedure.

Signature: __________________________________ Date:___________________________________