VEIN centers for excellence™ of Greenville
No one knows legs like we do!™

Patient Information Sheet

Name: _____ **Social Security #:** _____
(Last) (First) (Middle Initial)

DOB: _____ **Sex**: ○ Male ○ Female **Marital Status:** ○ Married ○ Single ○ Divorced ○ Widowed

Home Phone: ( ) _____ **Work Phone**: ( ) _____ **Cell:** ( ) _____

Email: _____

Mailing Address: _____
(Street) (City) (State) (Zip)

Referring Physician: _____ **Primary Care Physician:** _____

Emergency Contact: _____ **Phone:** ( ) _____ **Relationship**: _____

Patient Employed by: _____ **Phone:** ( ) _____

Work Address: _____
(Street) (City) (State) (Zip)

Spouse's Employer: _____ **Phone:** ( ) _____

Work Address: _____
(Street) (City) (State) (Zip)

Primary Insurance Coverage (Please Complete)

Name of Insurance Company: _____

Name of Insured: _____ **Group #:** _____

Insured's Place of Employment: _____ **Insured's SS #:** _____

Patient's Relationship to Insured: _____ **Insured's DOB** _____

Secondary Insurance Coverage (Please Complete)

Name of Insurance Company: _____

Name of Insured: _____ **Group #:** _____

Insured's Place of Employment: _____ **Insured's SS #:** _____

Patient's Relationship to Insured: _____ **Insured's DOB** _____

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payments of benefits.

AUTHORIZATION TO PAY BENEFITS TO PHYSCIAN:

I hereby authorize payment directly to Upstate Adult and Adolescent Medicine, PA of the surgical and/or benefits, if any, otherwise payable to me for their services.

Date: _____ **Signed** _____