VEIN CARE SPECIALISTS OF SOUTH FLORIDA
REGISTRATION SHEET

Last Name: ___________________________ First Name: ______________________ M.I. ______

Date of Birth: _________________________ Social Security No. ___________________________

Local Address: ____

City: _________________ State: ________ Zip:________ Local Phone No. (   ) ___________

What is the best number to call in regards to your appt(s):________________________________
Can we leave a detailed message regarding your appt?____________________________________

Other Address: ____________________________________ City: _______________ State _____

Zip: _______ From date: ___________ To Date: __________Other Phone No. (   )__________

How did you hear about us?____

E-mail:____

Name of Employer: _________________________________ Phone No. (   )_______________

Emergency Contact Name: ___________________________ Phone No. (   )_______________

Referring Physician Name: ____

Primary Insurance: _________________________ Secondary Insurance: _____________________

I hereby authorize any insurance benefits to be paid directly to the provider and recognize it is my responsibility to pay for all non-covered services. I also authorize the physician to release any information necessary to process an insurance claim. A parent or guardian who will be responsible for the payment of the bill at the time of service must accompany the patient. We cannot be bound by any divorce or other family relationship contracts.

____Signature/Date

Payment Amount $________

CPT	EXAM	DX