Surgical Specialists of Wayne County
Vein Specialty Center, dba
REGISTRATION FORM
(Please Print)

Primary Care Doctor: | Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one)

Street address: | Single / Mar / Div / Sep / Wid

City: | State: | Zip: | Birth date: / / | Age: | Sex: M F

Home phone no.: ( ) | Cell phone no.: ( ) | Social Security no.:

Occupation: | Employer: | Employer phone no.: ( )

Referred by: __Doctors office __Hospital __Print Ad

__ Family __ Friend __ Website __ Yellow Pages __ Other __Insurance Plan

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No Relationship to patient:

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No Primary Insurance:

Policy effective date: / /

Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature **Date**