

**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. Miss Mrs. 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: _____
 Family Friend Website Yellow Pages Other Insurance Plan
 Doctors office Hospital Print Ad

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