RESTORATION VEIN CARE

Patient Information

Name: _____ Date of Birth: _____ Gender: F M

Preferred Name: _____ Social Security #: _____

Home address: _____City _____State _____Zip: _____

Email: _____

Contact #s Home: (_____)_____Work: (_____)_____ Cell: (_____)_____

Employer: _____

Employer's address: _____City _____State _____Zip: _____

Spouse name: _____

Person to contact in case of emergency: _____

Relation to patient: _____ Telephone #: _____

Referring physician (if any): _____Phone:_____

Address: _____ City: _____

Primary care physician: _____ Phone: _____

Address: _____ City: _____

Health Insurance Information

Primary Insurance: _____ State: _____Policy # _____

Policy holder's name: _____ Date of birth: _____

Secondary Insurance: _____ State: _____Policy _____

Policy holder's name: _____ Date of birth: _____

Other Insurance: _____ State: _____Policy _____

Policy holder's name: _____ Date of birth: _____

How did you hear of our practice? □Referring Doctor □Friend/Family Member □Internet □Yellow Pages □Newspaper _____ □SJMH Employee □Magazine □Other

Authorization (for Medicare, Priority Health, HAP, Blue Care Network, and Blue Cross/Blue Shield plans)
I hereby authorize my insurance carriers to pay benefits directly to Restoration Vein Care, PLC. I understand that I am responsible to pay for any services not covered by my insurance. I also authorize release of pertinent medical information to my insurances carriers and the above-named physicians.

_____ _____
Signature Date

Located in the Reichert Health Building on the campus of St. Joseph Mercy Hospital
5333 McAuley Drive • Suite 4016 • Ypsilanti, Michigan 48197
734.712.4310 www.restorationveincare.com