

Welcome to our office!



NAME _____ DATE _____
FIRST MIDDLE LAST

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE () _____ BIRTH DATE _____ AGE _____

EMAIL _____ May we contact you via email? YES _____ NO _____

OCCUPATION _____ SSN _____

EMPLOYER _____ YEARS THERE _____

EMPLOYER'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

WORK PHONE () _____

Complete this section only if someone other than the patient is financially responsible.

RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE () _____ BIRTH DATE _____ AGE _____

EMAIL _____ May we contact you via email? YES _____ NO _____

OCCUPATION _____ SSN _____

EMPLOYER _____ YEARS THERE _____

EMPLOYER'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

WORK PHONE () _____

NAME OF SPOUSE _____ BIRTH DATE _____ AGE _____

OCCUPATION _____ SSN _____

EMPLOYER _____ YEARS THERE _____

EMPLOYER'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER'S PHONE () _____

In case of emergency, CONTACT _____ RELATIONSHIP _____

HOME PHONE () _____ WORK PHONE () _____

How did you hear about Veradia?

Referred by Dr. _____ Recommended by friend (Name) _____

Yellow Pages _____ Internet search engine _____

Print Advertising (check one): Argus Leader publication _____ Etc. magazine _____ SF Woman _____ Other _____

Other _____

Do you wish phone calls to be confidential? YES _____ NO _____

May we contact you at work? YES _____ NO _____

Insurance Information

PATIENT NAME _____ DATE _____
FIRST MIDDLE LAST

[PRIMARY INSURANCE]

NAME OF INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

INSURED'S NAME _____

GROUP NUMBER _____ POLICY ID NUMBER _____

[SECONDARY INSURANCE]

NAME OF INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

INSURED'S NAME _____

GROUP NUMBER _____ POLICY ID NUMBER _____

Did your injury happen on the job? YES _____ NO _____

If yes, on what date did the injury occur? _____

Did you report the accident to your employer? YES _____ NO _____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay and no-covered amounts. See our complete financial policy for details.

Method of payment for today's visit CASH _____ CHECK _____ VISA/MC _____

Signature of Patient or Responsible Party _____ Date _____

I authorize the release of any medical information necessary to process my claim.

Signed _____ Date _____
PATIENT OR RESPONSIBLE PARTY

I authorize payment of medical benefits to Veradia Interventional Radiology and Vein Center.

Signed _____ Date _____
PATIENT OR RESPONSIBLE PARTY