Scottsdale Vein Center Patient Information Form

PLEASE PRINT

General Information

Name:	☐ Mr. ☐ Miss ☐ Ms. ☐ Mrs. ☐ Dr	First	Middle	Last
Nickname:		Date of Birth: Month	Day	Year
Sex:	☐ Female ☐ Male	Height: (in inches)		Weight:
Marital Status:	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other ☐ Unknown			
Ethnicity:	☐ White ☐ Black ☐ Hispanic ☐ Other ☐ Unknown			
SSN:		Occupation:		
Primary Care Physician: Name & Phone #				
Who Referred you to Scottsdale Vein Center?				

Your Contact Information

Address	
City, State, Zip	
Home Phone:	( )
Cell Phone:	( )
Work Phone:	( )
Email Address:	

Emergency Contact Information

Full Name:	
Phone Number:	( ) -

Relationship :

☐ Husband ☐ Wife ☐ Son
☐ Father ☐ Mother ☐ Daughter

Office Use Only
Proof of Insurance copied ☐
Signature on file ☐

Insurance Information

Policy Number:	Plan Name	Group Number	Other Policies? ☐ Yes ☐ No
Insurance Type	☐ Medicare ☐ Champus ☐ Medicaid ☐ Champva ☐ Group (HMO, PPO, etc.) ☐ FECA ☐ None ☐ Other		
Effective Date: (mm/dd/yyyy)		Co-Pay ______ amount ______ percent	
Relationship to Insured:		Insured's Address:	
Insured's Name			
Phone	( )	Insured's Date of Birth (mm/dd/yyyy)	
Sex	☐ male ☐ female		
Signature			

Employer Information

Employer Name:		Phone: ( ) ___-____ Ext. ____
Employer Address:		