Columbus Vascular Vein & Wound Center

896 S State Street
Westerville, 43081

Phone: 614-917-0696
Fax: 888-732-7890
E-mail: info@cvvwc.com
Web: www.cvvwc.com

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CELLPHONE: _____

_____ HOMEPHONE: _____

_____ OTHER PHONE: _____

CITY STATE ZIP

May we leave messages on these numbers? ___Yes ___No Which phone number is best? ___Cell ___Home ___Other

☐ MALE ☐ FEMALE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED ☐ SIGNIFICANT OTHER

DATE OF BIRTH: _____ EMERGENCY CONTACT: _____

SOCIAL SEC. #: _____ PHONE NUMBER: _____

EMAIL: _____ RELATIONSHIP: _____

INSURANCE: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH: _____

I.D. NUMBER: _____

INSURANCE GROUP: _____

PATIENT RELATIONSHIP TO SUBSCRIBER:

☐ SELF ☐ SPOUSE ☐ CHILD ☐ DEPENDANT

PERSON RESPONSIBLE FOR BILL

(IF NOT PATIENT)

NAME: _____

ADDRESS: _____

_____

_____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to disclose my health care information to insurance companies and their agents for the purpose of obtaining payment for service.

PATIENT SIGNATURE: _____

TODAY'S DATE: _____