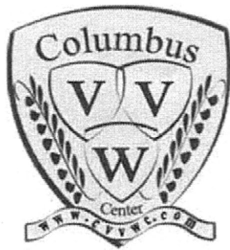

COLUMBUS VASCULAR VEIN & WOUND CENTER

895 S. State St
Westerville, OH 43081
http://www.cvvwc.com

phone: (614) 917-0696
fax: (888) 732-7890
email: info@cvvwc.com

PATIENT NAME: ______________________ DATE: ____________

ADDRESS: ______________________ CELL: ____________

______________________ HOME: ____________

______________________ Preferred Pharmacy: ____________

CITY ST ZIP

May we leave messages on these numbers? ___ Yes ___ No Which number is best? ___ Cell ___ Home ___Other

☐ MALE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

☐ FEMALE ☐ SINGLE ☐ SEPARATED ☐ SIGNIFICANT OTHER

DOB: ______________ Emergency Contact: ______________

SSN: ______________ Phone Number: ______________

Email: ______________ Relationship: ______________

INSURANCE INFORMATION

Insurance Provider: ______________

Subscriber Name: ______________

Subscriber DOB: ______________

I.D. Number: ______________

Insurance Group: ______________

PERSON RESPONSIBLE FOR BILL

(IF NOT PATIENT)

Name: ______________

Address: ______________

____

Relationship to Subscriber: ___ Self ___ Spouse ___ Child ___ Dependent ___ Other

PHYSICIAN INFORMATION

Referring Physician: ______________ Primary Physician: ______________

Phone: ______________ Phone: ______________

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: ______________________ **DATE / TIME:** ____________