



# SANTA BARBARA - V E I N C E N T E R -

## PATIENT INFORMATION FORM

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

Social Security: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Primary Physician (Full name): \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US: \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the Santa Barbara Vein Center to release any medical information to process a medical claim. I understand that the Santa Barbara Vein Center has the right to charge for a consultation once I am an established patient. I understand that I am financially responsible for any and all charges rendered at the time of the office visit and that fees are collected on the day of the procedure. If for any reason it becomes necessary to initiate collections proceedings, I understand I am responsible for the cost of all the treatments received, as well as any and all legal or collection fees the Santa Barbara Vein Center incurs.

SIGN: \_\_\_\_\_ DATE: \_\_\_\_\_