Virginia Vein Institute

1901 South Main Street (Suite 2)
BLACKSBURG, VA
540-552-8346 P
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Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Birth date: / /	Age:
Email:		Marital status (circle one) Single / Mar / Div / Sep / Wid			Sex: ☐ M ☐ F	
Street Address:		Social Security Number:			Home Phone :	
City:	State:	Zip Code:			Cell Phone:	
Occupation:	Employer:				Employer Phone:	
Referred By (Doctors Name):		Primary Care Doctor:			How did you find us (online, TV, Radio, Print, etc.)?	
Tel:		Tel:				

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Social Security No:	Home Phone :
Insured Address (if different from self):			Is this person a patient here? ☐ Yes ☐ No
Patient's relationship to subscriber:	☐ Self ☐ Spouse ☐ Child ☐ Other		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Phone:

SIGNATURE

Notice of Privacy Practices:

I acknowledge that I have been offered a copy of the Notice of Privacy Practices from Virginia Vein Institute. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Virginia Vein Institute or insurance company to release any information required to process my claims.

I agree, in order for you to service my account or collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. You may also contact me by sending text messages or emails, using any email address I have provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable. In the event that this account is placed with a collection agency, I shall pay all collections fees and costs.

Patient Signature **X**_____ Date:_____