ADVANCED VEIN & LASER CENTRE ™
REGISTRATION FORM

Date:	Chart #:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

E-mail:	Home phone no: ( )	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Cell phone no.: ( )

City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred to by (please check one box): ❑ Dr. _____

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Website ❑ Other

Please list referrals or other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)	Card Copied? ❑ Yes ❑ No

Is this patient covered by insurance? ❑ Yes ❑ No

Guarantor or Resp. Party:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Please indicate primary insurance:

Guarantor's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy 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:	Home phone no.: ( )	Work phone no.: ( )

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 Advanced Vein & Laser Centre or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*