# Connecticut Vascular Center

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## *ALL AREAS MUST BE COMPLETED*

## PATIENT INFORMATION

Patient Name: ______________________________________________

Address: ______________________________________________

City: ____________________ State: ____________ Zip: ____________

SS#: ____________________ M/S/D/W __________ DOB: ____________________ M/F

Phone(s) H: ______________ W: ______________ C: ______________

Employer ______________________________ Retired: ______________

Spouse: ______________________________________________

## EMERGENCY CONTACT NOT LIVING WITH YOU

Name: ______________ Relationship: ______________ Phone: ______________

Primary MD: ______________________________ Phone: ______________

## INSURANCE INFORMATION

PRIMARY Ins: ______________________ ID #: ______________________

Subscriber: ______________ SS #: ______________ Eff. Date: ______________

Date of Birth: ______________ Relationship to Patient: ______________________

SECONDARY Ins: ______________________ ID #: ______________________

Subscriber: ______________ SS #: ______________ Eff. Date: ______________

Date of Birth: ______________ Relationship to Patient: ______________________

Please show your insurance cards to our receptionist.
Any co-payments are expected at time of service. If you belong to an HMO and do not have a required referral, payment is expected at time of service.

## Please Read

I authorize direct payment of medical benefits from my insurance carrier be made to Connecticut Vascular Center, P.C. for any/all services furnished to me by them. I authorize release of my medical information about me to Medicare its agents or any other third party payers for the processing of medical insurance benefits. I agree to pay any amounts not paid by third party payers unless otherwise specified.

**This assignment remains valid unless revoked in writing.**

**Is this a worker's compensation case? Yes No**

**Is this a liability case? Yes No**

**Patient signature or
authorize agent: ______________________________ Date: ______________**

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