CONNECTICUT VASCULAR CENTER PC

DR. RALPH DE NATALE • DR. ANTOINE FERNEINI • DR. BRIAN COYLE • NANCY CHIN PA-C

PATIENT NAME: _____ **DATE OF BIRTH:** _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

SOCIAL SECURITY #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **PLEASE CIRCLE:** M / S / D / W

PHONE #: H) _____ C) _____ W) _____

EMPLOYER: _____ **RETIRED:** YES / NO

PRIMARY CARE PHYSCIAN: _____ **PHONE #:** _____

PREFERED PHARMACY: _____

E-MAIL ADDRESS: _____

EMERGENCY CONTACT: _____ **PHONE #:** _____

RELATIONSHIP: _____

INSURANCE INFORMATION

PRIMARY: _____ **ID #:** _____

SECONDARY: _____ **ID#:** _____

WORKMANS COMPENSATION CASE: YES / NO **LIABLITY CASE:** YES / NO

PLEASE GIVE INSURANCE CARDS TO RECEPTIONIST
ANY COPAYMENTS ARE EXPECTED AT TIME OF SERVICE. IF YOU BELONG TO AN HMO AND DO NOT HAVE REQUIRED REFERRAL, PAYMENT WILL BE EXPECTED AT TIME OF SERVICE.

PLEASE READ

I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS FROM MY INSURANCE CARRIER TO BE MADE TO CONNECTICUT VASCULAR CENTER PC FOR ANY/ALL SERVICES FURNISHED TO ME BY THEM. I AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO MEDICARE, ITS AGENTS, OR ANY 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.

PATIENT OR AUTHORIZED AGENT SIGNATURE: **DATE:**

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