## Vascular Specialists of Mobile, P.C.

DATE_____

PHYSICIAN_____

# Patient Information Sheet

LAST NAME_____FIRST NAME_____MI_____

MAILING
ADDRESS_____CITY_____STATE_____ZIP_____

SOCIAL SECURITY #_____SEX_____DATE OF BIRTH_____/_____/_____ AGE_____

HOME PHONE (  ) _____ CELL PHONE (  ) _____

MARITAL STATUS  S  M  W  D  SPOUSE NAME_____

SPOUSE BIRTHDATE_____/_____/_____ WORK PHONE (  )_____ OTHER PHONE (  )_____

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**EMERGENCY CONTACT INFORMATION**

NAME_____RELATIONSHIP_____PHONE (  )_____

NAME_____RELATIONSHIP_____PHONE (  )_____

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**REFERRING SOURCE**

REFERRED BY_____PHONE (  )_____

PCP NAME_____PHONE (  )_____

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**INSURANCE INFORMATION**

NAME OF INSURANCE COMPANY_____

POLICYHOLDER NAME_____POLICYHOLDER DATE OF BIRTH_____/_____/_____

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REASON FOR YOUR VISIT TODAY_____

**ASSIGNMENT, ACKNOWLEDGEMENT AND/OR GUANTEE OF PAYMENT**

1. Authorize the release of my medical information to any pertinent party, in addition to any insurance companies for the processing of my claims.
2. I authorize by signing below payment of medical benefits directly to my MD.
3. By signing below I acknowledge my understanding that I am financially responsible for any deductibles, non-covered services and balances not covered by my insurance carrier.
4. I agree that a photocopy of this form may be used in lieu of the original.
5. I acknowledge by singing below that I have received and read the Notice of Privacy Practices and Notice of Individual Rights.

Signature_____ Date_____