VARICOSE TO PERFECT

572 NORTH MAIN STREET
SPRINGBORO, OHIO 45066

PHONE: (937) 748-8905
TOLL FREE: (800) 716-VEIN
FAX: (937) 748-8906

PATIENT INFORMATION SHEET

First Name: ____________________ Last Name: ____________________ MI: ____________

Preferred Name: ____________________ E-mail Address: ______________________________

Social Security #: ____________________ Birth Date: ________________ Age: ____________

Gender: ____________ Marital Status: ____________ Height: __________Weight: __________

Address: ____

City: ______________________________________State:_____________ Zip: _____________

Home Phone: _____________________ Cell Phone: ___________________________________

Employer:____Work Phone: ___________________

Occupation:____

Employer Address: ____

City: ___________________________ State: ______________ Zip: ______________________

Emergency Contact: ________________________ Relationship: _________________________

Emergency Contact Phone: ____

Primary Physician: ____

REFERRAL SOURCE: ____

We may not be contracted with your insurance company.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Varicose to Perfect to release any medical information to process a medical claim. I understand that I am financially responsible for any and all charges rendered at the time of office visit and that fees are collected on the day of the procedure. If for any reason it becomes necessary to initiate collections proceedings, I understand I am responsible for the cost of all treatments received, as well as any and all legal or collection fees the company occurs.

SIGN ____ DATE ________________