ADVANCED VEIN CENTER

PATIENT REGISTRATION FORM

☐ Kenneth D. Osorio, M.D. ☐ Anabell Castro, NP-C

Last Name: ___________________________ First Name: _______________________ Middle Initial: _____

Street Address: ____

City: ___________________________________ State: _____________________ Zip Code: ___________

SSN: __________________ Birth Date: _________________ Age: _______ Marital Status: **S M W D**

Home Phone: _____________________________________ Work Phone: ____________________________

Driver's License #: ________________________________ Cell Phone: _____________________________

Do you authorize our office to leave messages at: HOME WORK CELL (circle all that apply)?

Occupation: ____

Employer: ____

Employer's Address: ____

Emergency Contact Name & Phone Number: ____

Primary Care Physician: ____ Phone: ______________________

Primary Insurance Company: ____________________________________ Phone: ______________________

Primary ID Number: ________________________________ Group Number: _________________________

Name of Insured: _____________________________________ SSN of Insured: ______________________

Birth Date of Insured: _________________________ Relationship to Insured: ________________________

Secondary Insurance: __________________________ Birth Date of Secondary: _______________________

Name of Secondary Insured: _____________________________SSN of Insured: ______________________

How did you hear about us? ☐Doctor Referral _________________________ Dr's Phone # ____________

☐Patient Referral ___________________________ ☐Other _____________________________________

I, the undersigned, grant permission to Advanced Vein Center to disclose medical information to other treating physicians regarding my care. I authorize the release to the Health Care Financing Administration or said insurance company and its agents any medical information about me to determine benefits payable for related services. I understand that, I the undersigned am legally responsible for all fees related to medical services rendered, including copayments, coinsurance and deductibles.

When canceling or rescheduling an appointment, 24 hour notice must be given or a $25 NO SHOW/CANCELLATION fee will be applied to my account.

I request that payment of authorized Medicare or health insurance benefits be made to Advanced Vein Center or Kenneth D. Osorio, MD for services furnished to me.

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Patient's Signature Date