THE VENOUS INSTITUTE OF BUFFALO, INC

Michael A. Vasquez, MD, FACS, RVT

PATIENT INFORMATION

(PLEASE PRINT)

Patient Name: _____ Patient SSN#: _____

Patient's Date of Birth: _____/ _____/ _____ Age: _____ Marital Status: _____

Sex: MALE FEMALE Street Address: _____

City, State, Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Patient's Employer: _____ Occupation: _____

Patient Insurance Type: _____

Name of Primary Doctor: _____

Name of Alternate/ Referring Doctor: _____

(FILL OUT THIS SECTION IF MARRIED)

Spouse Name: _____ Date of Birth: _____

Address: _____ SSN #: _____

Spouse's Employer: _____ Occupation: _____

Work Phone Number (_____) _____ Alternate Number (_____) _____

Pharmacy Name & Address: _____

_____

Case of Emergency Person: _____

Relationship: _____ Phone # (_____) _____

I authorize the use of this form on all of my insurance submission.
I authorize release of information to all of my insurance companies.
I understand that I am responsible for my bill.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.
I authorize payment directly made to my doctor.
I permit a copy of this authorization to be used in place of this original.

Patient Signature: _____ Date: _____

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