



**PATIENT REGISTRATION**

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 #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Emergency Contact Name & Phone Number: \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ SSN of Insured: \_\_\_\_\_

Date of Birth of Insured: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Primary ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Secondary ID Number: \_\_\_\_\_

**I, the undersigned, grant permission to Vein Associates of Edina 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.**

**I request that payment of authorized Medicare or health insurance benefits are to be made to Vein Associates for services furnished to me.**

**Patient:**           X \_\_\_\_\_

**Date:**            \_\_/\_\_/\_\_\_\_