Hamptons Vein & Vascular

PATIENT INFORMATION

NAME: ______________________ **AGE:** ______ **BIRTHDATE:** ______________

ADDRESS: ______________________ **HOME PHONE:** ______________________

______________________ **CELL PHONE:** ______________________

______________________ **WORK PHONE:** ______________________

OCCUPATION: ______________________ **EMAIL:** ______________________

SOCIAL SECURITY #______________________ **DRIVERS LICENSE #**______________________

SEX ( ) Male ( ) Female MARITAL STATUS ( ) Single ( ) Married ( ) Divorced ( ) Widow RACE ( )
American Indian/Alaskan Native ( )Asian ( )Black/African American ( )Pacific Islander ( )White Other: ____

PREFERRED PHARMACY: ______________________ **PHARMACY #:**______________________

HOW DID YOU HEAR ABOUT US? { } Friend { } Physician { } Newspaper { } Internet { } Other

EMERGENCY CONTACT AND PERSON WE MAY RELEASE INFORMATION TO

NAME: ______________________ **RELATION:** __________ **PHONE:**______________

NAME: ______________________ **RELATION:** __________ **PHONE:**______________

REFERRED BY ______________________ **PRIMARY PHYSICIAN**______________________
PHONE #: ______________________ **PHONE #:** ______________________

INSURANCE

Primary Insurance ______________________ **Policy Holder** ______________________

Contract #______________________**Group #** ____________ **Date-of-Birth** ____________

Secondary Insurance ______________________ **Policy Holder** ______________________

Contract #______________________**Group #** ____________ **Date-of-Birth** ____________

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Hamptons Vein & Vascular to release all medical records and pertinent medical information to any insurer, governmental agencies providing benefits, or to anyone liable for charges, I also authorize release of said information to my referring physician and to other medical providers who are or may become involved in my treatment.

PRIOR CONSENT TO CONTACT BY PHONE/CELL PHONE

I, the undersigned, give, Hamptons Vein & Vascular its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance and/or payment.
I authorize messages to be left on my answering machine and/or voicemail.

CONSENT TO TREAT

I consent to examination, diagnosis, and general medical care and treatment (including, but not limited to physical examinations, administration of medications and vaccinations, recordings and/or photographs for diagnosis and/or treatment, the taking of x-rays, blood draws, diagnostic tests, laboratory tests, and other minor procedures) to be performed by employees, including but not limited to physicians, nurses, and assistants of Hamptons Vein & Vascular.

SIGNATURE______________________________ **DATE**______________________