WILLAMETTE
VASCULAR SPECIALISTS, P.C.

PATIENT REGISTRATION

Name:_____
Last First MI

Address:_____City: _____State: _____ Zip: _____

Sex: ❒F ❒M Date of Birth ____/____/____

Social Security #:_____-_____-_____

Patient's Employer _____

Occupation:_____

Marital Status: ❒Single ❒Married ❒Widow/Widowed

Spouse's Name _____

Message may be left on:
❒Answering Machine / Voice Mail ❒Work Phone

Home Phone:	Work Phone:	Cell Phone:
( )	( )	( )

Email Address:

REFERRING PHYSICIAN(S)

Referred By:_____
(Last) (First) (Phone#)

Primary Care Physician: _____
(Phone#)

Send additional reports to the following physicians:_____
Name Phone#

Name Phone# Name Phone#

INSURANCE

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD, AND PAY YOUR APPLICABLE CO-PAYMENT.

Primary Insurance: _____

Secondary Insurance: _____

❒ **No Insurance**

Emergency Information: Person to contact in case of emergency, NOT LIVING at the above address.
Name: _____ Relationship to Patient: _____

Address: _____ Phone: (_____) _____

City: _____ State: _____ Zip: _____

I authorize the physicians and staff of Willamette Vascular Specialists P.C to release information regarding my condition and/or treatment to: _____

Please read the following statement carefully before signing.

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to receive all benefits to which my departments or I are entitled to under my health insurance plan. I also authorize the healthcare provider insurance company to release any information required for this claim. In addition, I will not withhold or delay payment if my insurance company denied payment on any of my charges. The undersigned agrees that whether he/she signs as an agent, that he/she is obligated to pay for the account.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.
Signature: _____ Relationship to Patient: _____

Date: _____

Experience • Integrity • Compassion