



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:		
<input type="checkbox"/> Answering Machine / Voice Mail <input type="checkbox"/> 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#
_____	_____	_____	_____

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: _____