REGION VEIN
EXCEPTIONAL VEIN CARE

Demetrios J. Karamichos, MD
RPVI, RVT, DABVLM, FAAFP

REGION VEIN PATIENT REGISTRATION FORM

(PLEASE PRINT) Today's date: _____

PATIENT INFORMATION

Name: _____ Age: _____ Date of Birth: _____
LAST FIRST MI

Mailing Address: _____
STREET CITY STATE ZIP CODE

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Work Email Address: _____

Sex: _____ Marital Status: _____ Spouse's Name: _____

Driver's License Number: _____ SSN: _____

Employer: _____ Employer Address: _____

Primary Care Physician: _____ PCP Address: _____

PARENT OR RESPONSIBLE PARTY (if different from Patient)

Name: _____
LAST FIRST MI

Mailing Address: _____
STREET CITY STATE ZIP CODE

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ SSN: _____ Relationship to Patient: _____

Employer: _____ Employer Address: _____

INSURANCE INFORMATION

Primary Insurance Co. Name: _____ Policy Holder: _____

Policy Holder Date of Birth: _____ Relationship to Patient: _____

Member ID: _____ Group Number: _____

Secondary Insurance Co. Name: _____ Policy Holder: _____

Policy Holder Date of Birth: _____ Relationship to Patient: _____

Member ID: _____ Group Number: _____

EMERGENCY CONTACT

Name: _____ Phone Number: _____

I hereby authorize the above practice to disclose or receive any or all information relating to my evaluation at this office, including copies of my diagnostic test results, to or from my attending physician and/or such physicians as may be selected by my attending physician, at his or her discretion, for the purpose of obtaining further diagnosis and/or treatment which he or she believes is indicated.
I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.
I am responsible for any referrals and/or authorizations required by my insurance company. I understand I am financially responsible for any balance not covered by my inssurance.
I understand that the above practice is not responsible for collecting on an insurance claim or negotiating a settlement on a disputed claim. I agree that I am responsible for any co-payments, deductibles and fees for non-covered services.

I understand that the above practice is not in the business of extending credit and I agree to pay the above practice at the time the bill is presented. If prompt payment is not made, the above practice may take action to collect its charges.

Signature: _____ Date: _____