

VASCULAR SURGERY ASSOCIATES P.A.



Dr. Beezley, Dr. Arnsperger, Dr. Connelly, Dr. Hance

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vascularsurgeryassoc.net

Patient Information

Name _____ Date of birth _____ Age ____ Sex: Male Female

Address _____

Are you presently in a nursing facility? Yes No If yes, what is the name? _____

Best contact number: _____ home cell work nursing home

Alternate contact number: _____ home cell work nursing home

email: _____

Your SSN: _____ Marital status: single married divorced widowed

Emergency contact _____ Relationship _____ Phone number _____

Referred by _____ Primary Physician _____

Phone number _____ Phone number _____

Fax number _____ Fax number _____

Pharmacy of choice _____ Phone number _____

Hospital of choice: 1. _____ 2. _____

How did you hear about us? Primary Physician Friend Advertisement Insurance Other: _____

Primary insurance _____ ID Number _____ Group Number _____

Is this an HMO? _____ Is a referral required? Yes No

Name of insured _____ relationship _____

Secondary insurance _____ ID Number _____ Group Number _____

Name of insured _____ relationship _____

Authorization and Release

I authorize the doctor and his staff to release any information including the diagnosis and records of treatment or examination to third party payers and/or other health care practitioners. I give consent for other health practitioners and medical facilities to release medical records to Vascular Surgery Associates P.A. as it relates to my continuing care. I understand that this consent is good for one year from the date signed and maybe revoked at any time in writing. I authorize and request my insurance company to pay directly to Dr. Michael Beezley/Dr. Richard Arnsperger/Dr. Daniel Connelly/Dr. Kirk Hance any benefits covered by my insurance plan. I understand that my insurance may pay less than the actual bill for service. I agree that I am responsible for any charges for services rendered to myself or my dependent.

Yes No I consent to have detailed messages and test results left on an answering machine, voice mail, or email.

Yes No I would like to have information released to my employer.

Signature _____ Date _____

(IF APPLICABLE)

Signature of authorized representative:

_____ Relationship _____ Date _____

Address _____ Phone number _____