Southern Arizona Laser & Vein Institute

6422 East Speedway Boulevard - Suite 150 - Tucson, Arizona 85710
Phone: (520) 318-3004 Fax: (520) 318-3061 www.SALVI-Tucson.com

PATIENT REGISTRATION FORM

Account # _____ Date _____

Patient Name: _____ M _____ F _____
Last First Legal Nickname MI

Is this your legal name? Yes _____ No _____ If no, what is your legal name? _____

Marital Status: Single ____ Married ____ Divorce ____ Widow ____ Spouse's Name: _____

Street Address: _____ PO Box: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____ Phone # _____

Date of Birth: _____ Age: _____ Social Security #: _____ Cell #: _____

Your Employer: _____ Phone# _____ Occupation: _____

Primary Care Physician: _____ Phone #: _____

Referring Physician (if different) _____ Phone #: _____

INSURANCE INFORMATION

Are you covered by health insurance? Yes ____ No ____ **If No, please make payment arrangements with our business office.**

Primary Insurance _____ Policy # _____ Group # _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Social Security Number _____ Copay _____

Secondary Insurance _____ Policy # _____ Group # _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Social Security Number _____ Copay _____

If this visit related to an at work injury? Yes _____ No _____ If yes, Employer at time of injury _____

Date of Injury _____ Insurance Info _____ Claim # _____

EMERGENCY CONTACT

Emergency Contact _____ Relationship to Patient _____

Phone # _____ Cell # _____ Date of Birth _____

PLEASE COMPLETE AND SIGN THIS RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS

"I hereby authorize Southern Arizona Laser & Vein Institute to release to or to request from any insurance company, other physician or hospital, any information including the diagnosis and records of any treatment or examination rendered to me during surgical care. This includes any financial information. This information may be faxed. I also authorize and request my insurance companies to pay directly to the above named corporation the amount due on any pending insurance claim for medical and/or surgical treatment or service. I also understand that if it becomes necessary to refer my account to collections, I will be liable for the reasonable collection fees and court costs expended therein." I understand that there is a $25 pre-paid fee for all disability forms filled out by the physician. The physicians reserve the right to charge interest on unpaid accounts.

PATIENT SIGNATURE: _____ DATE: _____
(Or parent/guardian if patient is a minor) "Duplicate of this release & assignment is as valid as the original"