Date: \_\_\_\_\_



Street Address:	Last Name:		First:		MI:
City: State: Zip: Cell Phone: ( )  Employer: Work Phone: ( )  Sex: Marital Status: Social Security Number: Deteor of Birth (MM/DD/YYYY): Cocupation: E-mail: PharmacyName: PharmacyName: PharmacyPhone#: Spouse, Parent /Guardian (Sponsor) Information: Spouse Name: Date of Birth (MM/DD/YYYY): Employer: Employer: Employer Phone: ( )  Spouse Name: PharmacyName: Phone: ( )  Spouse Social Security Number: Employer Phone: ( )  Spouse Social Security Number: Employer Phone: ( )  Relationship to patient: Phone: ( )  Insurance: Please list all insurances that you currently have. We are not responsible for filling insury you do not provide us with correct insurance information. We do not participate with Tenn Care or Medie Primary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy Holder is: self / spouse (pleas Secondary: Policy Holder is: self / spouse (pleas Referring Physicians. Name Address Telephone  Referring Physician: Primary Care Physician: OB/GYN: Primary Care Physician: OB/GYN: Interest provider or ganizations, or its intermediaries or carriers. I further authorize East Tennesse Vein Clinic, P.C., when and as requested, to disclose any or all pertinen of information in my medical records to my physicians listed above and any persons, corporation, or agency which is be liable for all or part of this office's services, including but not limited to, insurance companies, health main organizations, referred provider organizations, or its intermediaries or carriers. I further authorize East Tenness Clinic, P.C. obisclose such information to its insurance carrier or carriers when so requested by the carrier.  I also authorize and direct the named insurer to pay directly to East Tennessee Vein Clinic, P.C. any or all benefits a amount of my bill accruing to me in connection to my treatment.  I understand I am financially responsible to pay East Tennessee Vein Clinic, P.C. for services Dr. Douglass and a personnel provide. If after my insurance is filed, and it is determined that any procedures were not	Street Address:			Home Phone	: ()
Employer:	City:	State:	Zip:	Cell Phone :	
Sex:				Work Phone:	
Occupation:				Number:	· ,
Occupation:	Date of Birth (MM/DD/YY	YY):			
Pharmacy Name:	Occupation:	<i>,</i>	E-ma	uil:	
Spouse, Parent /Guardian (Sponsor) Information:  Spouse Name:	PharmacyName:		PharmacyAddre	ss:	
Spouse, Parent /Guardian (Sponsor) Information:  Spouse Name:	Pharmacy Phone#:		·		
Spouse Name:			r) Information	on:	
Employer:					YYY):
Spouse Social Security Number:					
Emergency Contact:  Name:					
Relationship to patient:	•				<del></del>
Relationship to patient:  Insurance: Please list all insurances that you currently have. We are not responsible for filling insuryou do not provide us with correct insurance information. We do not participate with Tenn Care or Medic Primary:  Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy ID: Policy holder is: self / spouse (pleas Self /	<b>.</b>		Phon	a: ( )	
Insurance: Please list all insurances that you currently have. We are not responsible for filling insury you do not provide us with correct insurance information. We do not participate with Tenn Care or Medie Primary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas Secondary: Policy ID: Policy holder is: self / spouse (pleas We request your permission to send a brief report of the services provided to our patients' referring, primary car OB/GYN physicians Address Telephone Referring Physician:					
you do not provide us with correct insurance information. We do not participate with Tenn Care or Medic Primary:	_				1.1 0 0111
Primary:		•	•	_	_
Secondary:					
We request your permission to send a brief report of the services provided to our patients' referring, primary car OB/GYN physicians.  Name Address Telephone  Referring Physician:  Primary Care Physician:  OB/GYN:  Release of information, insurance benefit determinations, and payment: I hereby authorize and direct East Tennessee Vein Clinic, P.C., when and as requested, to disclose any or all pertinem of information in my medical records to my physicians listed above and any persons, corporation, or agency which is be liable for all or part of this office's services, including but not limited to, insurance companies, health mair organizations, referred provider organizations, or its intermediaries or carriers. I further authorize East Tenness Clinic, P.C. to disclose such information to its insurance carrier or carriers when so requested by the carrier.  I also authorize and direct the named insurer to pay directly to East Tennessee Vein Clinic, P.C. any or all benefits a amount of my bill accruing to me in connection to my treatment.  I understand I am financially responsible to pay East Tennessee Vein Clinic, P.C. for services Dr. Douglass and a personnel provide. If after my insurance is filed, and it is determined that any procedures were not a covered sunderstand that I am still financially responsible for all services rendered. Please initial here:  How did you hear about East Tennessee Vein Clinic? Please check all that apply:  Physician referral  Friend or Family	Sacardamy	Policy	ID:	Policy noider is:	Self / spouse (please circle)
OB/GYN physicians.  Referring Physician:  Primary Care Physician:  OB/GYN:  Release of information, insurance benefit determinations, and payment: I hereby authorize and direct East Tennessee Vein Clinic, P.C., when and as requested, to disclose any or all pertinem of information in my medical records to my physician listed above and any persons, corporation, or agency which is be liable for all or part of this office's services, including but not limited to, insurance companies, health main organizations, referred provider organizations, or its intermediaries or carriers. I further authorize East Tennesse Clinic, P.C. to disclose such information to its insurance carrier or carriers when so requested by the carrier.  I also authorize and direct the named insurer to pay directly to East Tennessee Vein Clinic, P.C. any or all benefits a amount of my bill accruing to me in connection to my treatment.  I understand I am financially responsible to pay East Tennessee Vein Clinic, P.C. for services Dr. Douglass and a personnel provide. If after my insurance is filed, and it is determined that any procedures were not a covered so understand that I am still financially responsible for all services rendered. Please initial here:  How did you hear about East Tennessee Vein Clinic? Please check all that apply:  Physician referral	Secondary:	Policy	ID:	Policy holder is:	Sell / Spouse (please circle)
Primary Care Physician:  OB/GYN:  Release of information, insurance benefit determinations, and payment:  I hereby authorize and direct East Tennessee Vein Clinic, P.C., when and as requested, to disclose any or all pertinent of information in my medical records to my physicians listed above and any persons, corporation, or agency which is be liable for all or part of this office's services, including but not limited to, insurance companies, health main organizations, referred provider organizations, or its intermediaries or carriers. I further authorize East Tenness Clinic, P.C. to disclose such information to its insurance carrier or carriers when so requested by the carrier.  I also authorize and direct the named insurer to pay directly to East Tennessee Vein Clinic, P.C. any or all benefits amount of my bill accruing to me in connection to my treatment.  I understand I am financially responsible to pay East Tennessee Vein Clinic, P.C. for services Dr. Douglass and a personnel provide. If after my insurance is filed, and it is determined that any procedures were not a covered so understand that I am still financially responsible for all services rendered. Please initial here:  How did you hear about East Tennessee Vein Clinic? Please check all that apply:  Physician referral  Friend or Family TV		-	•	•	
Primary Care Physician:  OB/GYN:  Release of information, insurance benefit determinations, and payment:  I hereby authorize and direct East Tennessee Vein Clinic, P.C., when and as requested, to disclose any or all pertinent of information in my medical records to my physicians listed above and any persons, corporation, or agency which is be liable for all or part of this office's services, including but not limited to, insurance companies, health main organizations, referred provider organizations, or its intermediaries or carriers. I further authorize East Tenness Clinic, P.C. to disclose such information to its insurance carrier or carriers when so requested by the carrier.  I also authorize and direct the named insurer to pay directly to East Tennessee Vein Clinic, P.C. any or all benefits amount of my bill accruing to me in connection to my treatment.  I understand I am financially responsible to pay East Tennessee Vein Clinic, P.C. for services Dr. Douglass and a personnel provide. If after my insurance is filed, and it is determined that any procedures were not a covered so understand that I am still financially responsible for all services rendered. Please initial here:  How did you hear about East Tennessee Vein Clinic? Please check all that apply:  Physician referral  Friend or Family TV	Referring Physician:				
Release of information, insurance benefit determinations, and payment:  I hereby authorize and direct East Tennessee Vein Clinic, P.C., when and as requested, to disclose any or all pertinent of information in my medical records to my physicians listed above and any persons, corporation, or agency which is be liable for all or part of this office's services, including but not limited to, insurance companies, health main organizations, referred provider organizations, or its intermediaries or carriers. I further authorize East Tenness Clinic, P.C. to disclose such information to its insurance carrier or carriers when so requested by the carrier.  I also authorize and direct the named insurer to pay directly to East Tennessee Vein Clinic, P.C. any or all benefits a amount of my bill accruing to me in connection to my treatment.  I understand I am financially responsible to pay East Tennessee Vein Clinic, P.C. for services Dr. Douglass and a personnel provide. If after my insurance is filed, and it is determined that any procedures were not a covered sunderstand that I am still financially responsible for all services rendered. Please initial here:  How did you hear about East Tennessee Vein Clinic? Please check all that apply:  Physician referral  Friend or Family					
Release of information, insurance benefit determinations, and payment:  I hereby authorize and direct East Tennessee Vein Clinic, P.C., when and as requested, to disclose any or all pertinent of information in my medical records to my physicians listed above and any persons, corporation, or agency which is be liable for all or part of this office's services, including but not limited to, insurance companies, health main organizations, referred provider organizations, or its intermediaries or carriers. I further authorize East Tenness Clinic, P.C. to disclose such information to its insurance carrier or carriers when so requested by the carrier.  I also authorize and direct the named insurer to pay directly to East Tennessee Vein Clinic, P.C. any or all benefits a amount of my bill accruing to me in connection to my treatment.  I understand I am financially responsible to pay East Tennessee Vein Clinic, P.C. for services Dr. Douglass and a personnel provide. If after my insurance is filed, and it is determined that any procedures were not a covered sunderstand that I am still financially responsible for all services rendered. Please initial here:  How did you hear about East Tennessee Vein Clinic? Please check all that apply:  Physician referral  Friend or Family	OB/GYN:				
I hereby authorize and direct East Tennessee Vein Clinic, P.C., when and as requested, to disclose any or all pertinent of information in my medical records to my physicians listed above and any persons, corporation, or agency which is be liable for all or part of this office's services, including but not limited to, insurance companies, health main organizations, referred provider organizations, or its intermediaries or carriers. I further authorize East Tenness Clinic, P.C. to disclose such information to its insurance carrier or carriers when so requested by the carrier.  I also authorize and direct the named insurer to pay directly to East Tennessee Vein Clinic, P.C. any or all benefits amount of my bill accruing to me in connection to my treatment.  I understand I am financially responsible to pay East Tennessee Vein Clinic, P.C. for services Dr. Douglass and a personnel provide. If after my insurance is filed, and it is determined that any procedures were not a covered sunderstand that I am still financially responsible for all services rendered. Please initial here:  How did you hear about East Tennessee Vein Clinic? Please check all that apply:  Physician referral  Friend or Family					
amount of my bill accruing to me in connection to my treatment.  I understand I am financially responsible to pay East Tennessee Vein Clinic, P.C. for services Dr. Douglass and a personnel provide. If after my insurance is filed, and it is determined that any procedures were not a covered sunderstand that I am still financially responsible for all services rendered. Please initial here:  How did you hear about East Tennessee Vein Clinic? Please check all that apply:  Physician referral	I hereby authorize and direct East of information in my medical re- be liable for all or part of this organizations, referred provider	st Tennessee Vein Cli cords to my physician office's services, inc organizations, or its	nic, P.C., when and as listed above and a cluding but not lin intermediaries or	as requested, to disclosing persons, corporation ited to, insurance concarriers. I further aut	se any or all pertinent aspects n, or agency which is or may npanies, health maintenance horize East Tennessee Vein
personnel provide. If after my insurance is filed, and it is determined that any procedures were not a covered so understand that I am still financially responsible for all services rendered. Please initial here:  How did you hear about East Tennessee Vein Clinic? Please check all that apply:  Physician referral  Friend or Family  TV  Yellow page.		ž •	•	nessee Vein Clinic, P.C	. any or all benefits up to the
☐ Physician referral ☐ Friend or Family ☐ TV ☐ Yellow pa	personnel provide. If after my	insurance is filed, an	d it is determined	that any procedures w	rere not a covered service, I
How may we contact you: (Please circle your response)  We may / may not: leave a detail message on your answering machine.  We may / may not: leave a detail message with someone at home.  We may / may not: call you at work.  We may / may not: email you	☐ Physician referral ☐ Newspaper  How may we contact you: We may / may not: leave We may / may not: leave We may / may not: call y	Friend or Famil ETVC Web Site (Please circle your a detail message of a detail message vou at work.	y $\square$ To response) on your answering	V ternet Search (I.e.Goo g machine.	☐ Yellow pages

Patient Signature: \_\_\_\_\_