East Tennessee
VEIN CLINIC

Patient Information

Last Name: _____ First: _____ MI: _____
Street Address: _____ Home Phone: (___)_____
City: _____State: _____Zip: _____ Cell Phone : (___)_____
Employer: _____ Work Phone: (___)_____
Sex: _____ Marital Status: _____ Social Security Number: _____
Date of Birth (MM/DD/YYYY): _____
Occupation: _____ E-mail:_____
PharmacyName:_____PharmacyAddress:_____
Pharmacy Phone#: _____

Spouse, Parent /Guardian (Sponsor) Information:

Spouse Name: _____ Date of Birth (MM/DD/YYYY): _____
Employer: _____ Employer Phone: (_____)_____
Spouse Social Security Number: _____

Emergency Contact:

Name: _____ Phone: (_____)_____
Relationship to patient: _____

Insurance: Please list all insurances that you currently have. We are not responsible for filling insurance if you do not provide us with correct insurance information. We do not participate with Tenn Care or Medicaid.
Primary: _____ Policy ID: _____Policy holder is: self / spouse (please circle)
Secondary:_____ Policy ID: _____Policy holder is: self / spouse (please circle)

We request your permission to send a brief report of the services provided to our patients' referring, primary care and/or 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 pertinent aspects of information in my medical records to my physicians listed above and any persons, corporation, or agency which is or may be liable for all or part of this office's services, including but not limited to, insurance companies, health maintenance organizations, referred provider organizations, or its intermediaries or carriers. I further authorize East Tennessee Vein 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 up to the 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 ancillary personnel provide. If after my insurance is filed, and it is determined that any procedures were not a covered service, I 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 pages
☐ Newspaper ☐ ETVC Web Site ☐ Internet Search (I.e.Google) ☐ Other

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

Patient Signature: _____ Date: _____