MEMPHIS VASCULAR CENTER

PATIENT REGISTRATION

CHART #: _____DATE: _____

PATIENT INFORMATION

Pt Home Ph #:_____Pt Cell #:_____Pharmacy #:_____DOB:_____

Patient's Last Name:_____First Name:_____MI:_____

Address:_____City:_____ST_____ZIP:_____

Email address:_____SSN:_____Sex: M F Marital Status: S M D W Separated

Referred By: Physician [ ] Friend/Relative [ ] Emergency Room [ ] Yellow Pages [ ] Other: _____

Referring Physician:_____Physician Phone:_____

Physician Address:_____City:_____ST:_____ZIP:_____

Employer:_____Employer Phone:_____

Employer Address:_____City:_____ST:_____ZIP:_____

Emergency Contact:_____Contact Phone:_____

Emg Contact Address:_____City:_____ST:_____ZIP:_____

RESPONSIBLE PARTY

Last Name:_____First Name:_____MI:_____

Address:_____City_____ST:_____ZIP:_____

Phone No (Home):_____DOB:_____SSN:_____

Employer Name:_____ Employer Phone:_____

Employer Address:_____City:_____ST:_____ZIP:_____

INSURANCE INFORMATION

Primary Insurance Company:_____Ins Co Phone:_____

Policy Holder:_____DOB:_____SSN:_____

Policy Holder Address:_____City:_____ST:_____ZIP:_____

Policy No:_____Group No:_____Ref No:_____

Other Ins Co:_____Ins Co Phone:_____

Policy Holder:_____DOB:_____SSN:_____

Policy Holder Address:_____City:_____ST:_____ZIP:_____

Policy No:_____Group No:_____Ref No:_____

ASSIGNMENT OF BENEFITS:
I hereby authorize the verification of my medical benefits and payments directly to the treating physician. I understand that I am responsible for any portion of my bill not covered by my insurance company.

RELEASE OF INFORMATION:
I hereby authorize the treating physician to release any information required in the course of my treatment to my insurance.

GUARANTEE OF PAYMENT:
I understand that pre-authorization is not a guarantee of payment from the insurance company. Memphis Vascular Center (Memphis Radiological, P.C.) will bill for the services rendered, but I understand that any agreement is between my insurance company and me. If any amount due for the service rendered becomes delinquent and the debt is assigned to a third party for collections, it is understood that court costs, attorney's fees and other reasonable costs of collection may be added to the amount of the account.

SIGNATURE (Responsible Party): _____DATE: _____

SIGNATURE (Witness): _____DATE: _____