

First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____ E-mail Address: _____

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

Gender: _____ Marital Status: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Primary Physician (Full Name): _____

Primary Insurance Company: _____

HOW DID YOU HEAR ABOUT US: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize The North Shore Vein Center to release any medical information to process a medical claim. I understand that The North Shore Vein Center has the right to charge for a consultation once I am an established patient. I understand that I am financially responsible for any and all charges rendered at the time of office visit and that fees are collected on the day of the procedure. If for any reason it becomes necessary to initiate collections proceedings, I understand I am responsible for the cost of all treatments received, as well as any and all legal or collection fees The North Shore Vein Center incurs.

SIGN _____ DATE _____