Last Name: _____ **First:** _____ **M.I.:** _____

DOB: _____ **Age:** _____ **SSN:** _____ **Sex:** ☐Male ☐Female

Race: _____ **Preferred Language:** _____ **Marital Status:** _____

Mailing Address:

Street: _____ **Apt:** _____ **City**: _____

State: _____ **Zip**: _____

Patient Contact Info:

Home Phone or Land Line: _____ **Cell Phone**: _____

Work Phone: _____ **Primary:** ☐ Home ☐Cell

Email: _____ **Current Pharmacy:** _____

Emergency Contact Information:

Name: _____ **Relationship:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

Insurance Info: Skip if cards given to staff

Primary Insurance: _____ **Name on Card:** _____ **DOB:** _____

Secondary Insurance: _____ **Name on Card**: _____ **DOB**: _____

_____ **Authorization for Release of Information: I am authorizing VITA and Vita Veins to release all my medical information (including but not limited to, information on psychiatric conditions, alcohol and drug abuse: requested by my health insurance carrier or any other third-party payers as well as my primary physician and referring physician. I authorize VITA and Vita Veins to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to VITA and Vita Veins.**

_____ **Assignment of Benefits: I request that payment of authorized insurance benefits be made on my behalf to VITA and Vita Veins. I understand I am responsible for any balances not covered by insurance.**

Patient/Guardian Signature: _____ **Date:** _____

Guardian Name (Print): _____