Last Name: ______________________________ **First:** _____________________________ **M.I.:** _________________

DOB: _____________________ **Age:** _____________ **SSN:** ________________________ **Sex:** ☐Male ☐Female

Race: _____________ **Ethnic Group:** ___________ **Preferred Language:** ____________ **Marital Status:** ___________

Primary Address:

Street: ____ **Apt**: __________ **City**: ______________________________

State: ________ **Zip**: ____________

Mailing Address: Check here if same as Primary ☐

Street: ____ **Apt**: __________ **City**: ______________________________

State: ________ **Zip**: ____________

Home Phone: ____________________________ **Cell Phone**: __________________________ **Primary #:** ☐ Home ☐Cell

Drivers Lic #: __________________________________ **St:** _____ **Expr:** ________**Email:** _____________________________

Primary Care Physician: _____________________________ **Last Visit Date:** ______________ **Phone:** _________________

Referring Physician: ________________________________ **Last Visit Date:** _______________ **Phone:** ________________

Emergency Contact Information:

Name: ____ **Relationship:** _____________________________________

Address: ____

Home Phone: _____________________ **Cell Phone:** ___________________________

Primary Insurance Information:

Primary Insurance: _______________________________________ **Name on Card:** ______________________________

Policy #: _____________________________________ **Group #:** ________________________ **DOB:** ________________

Secondary Insurance Information:

Primary Insurance: _______________________________________ **Name on Card**: ______________________________

Policy #: _____________________________________ **Group #:** ________________________ **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, Medicare or any other third-party payers. I authorize VITA and Vita Veins to release all my medical information to my referring physician and my primary 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.

Patient/Guardian Signature: ____ **Date:** __________________________

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): ____