ALASKA VEIN CLINIC NEW PATIENT REGISTRATION

Date of Office Visit: ______/______/______ Age: _____ Birthdate: ______/______/______ Sex: F M

Last Name: ________________________________ First Name: ____________________________ Middle I: ______

Mailing Address: _______________________________________ City: ________________ State_____ Zip _________

Main Contact Phone: (_____) _____ - ________ Alternate Phone Phone: (_____) _____ - ________

email: ____@______________________.___________

How would you like us to contact you (check all that apply): telephone text e-mail

Marital Status: Married Single Partnered Divorced Widowed

Race: ________________________ prefer not to say. / Ethnic Group: ___________________ prefer not to say.

Occupation: ____ SSN# _______/______/__________

Employer: ____ Work phone: (_____) _____ - ________

Spouse / Partner Name: ____

Spouse / Partner Name: ____

Spouse Partner DOB ______/_______/________ Spouse Partner SSN# _______/______/__________

Primary Insurance: ____

Insured: Self Spouse Other ______________________________________

Secondary Insurance: ____

Insured: Self Spouse Other ____

How did you find out about us: Physican Web Search Friend TV Ad Radio Ad Print Ad

Name / Details ____

Contact Name: ____ Phone (______) ______ -________

I consent to treatment necessary for the care of the above-named patient or myself. I hereby authorize the release of any information acquired in the course of this visit or subsequent visits to my insurance providers and referring physicians. I authorize the payment of medical benefits directly to the Robert R Artwohl, M.D., P.C. and the Alaska Vein Clinic. I understand that I am responsible for all charges, regardless of insurance coverage.

Check here if we can discuss your medical issues with your spouse/partner.

Signature ____ Date: ______/______/______

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