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 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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