LAFAYETTE OB-GYN
ADVANCED VEIN CENTER

PATIENT REGISTRATION (Please Print) DATE____________
(office use)- Physician: DJW JMH (circle) Acct #____________

PATIENT NAME ________________________
SOCIAL SECURITY # ________________________
MARITAL STATUS (circle one) S M D W
DATE OF BIRTH ________________________
STREET ADDRESS ________________________
CITY ____________ STATE ______ ZIP ______
HOME PHONE ( ) ____________ CELL PHONE ( ) ____________
EMPLOYER ________________________
EMPLOYER PHONE ( ) ____________ EXT. ______
E-MAIL ADDRESS ________________________
REFERRING PHYSICIAN ________________________
EMERGENCY CONTACT NAME ________________________
PHONE ____________ RELATIONSHIP ____________

SPOUSE INFORMATION

SPOUSE NAME ________________________
SPOUSE EMPLOYER ________________________
SPOUSE EMPLOYER PHONE ( ) ____________
SOCIAL SECURITY # ________________________
DATE OF BIRTH ________________________

RESPONSIBLE PARTY INFORMATION (PARENT OR GUARDIAN IF PATIENT IS UNDER AGE 18)

NAME ________________________
RELATIONSHIP TO PATIENT ________________________
STREET ADDRESS ________________________
CITY ____________ STATE ______ ZIP ______
HOME PHONE ( ) ________________________
EMPLOYER ________________________
EMPLOYER PHONE ( ) ____________

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO MY PHYSICIAN AT LAFAYETTE OB-GYN/ADVANCED VEIN CENTER. I FURTHER AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION REQUESTED BY MY INSURANCE COMPANY FOR THE PURPOSE OF DETERMINING MY INSURANCE BENEFITS FOR SERVICES THAT ARE RECEIVED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURANCE COVERAGE AND I ACCEPT RESPONSIBILITY FOR ANY COLLECTION COSTS THAT MAY RESULT FROM NON-PAYMENT.

Patient/Guardian signature ________________________
Date ____________