Cincinnati Vein Specialists

Patient Registration Form

Important: Please print!

Last Name _____ DOB_____

First Name_____ SSN_____

Middle_____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____

Cell Phone _____

Work Phone _____

Marital Status: Single Married Divorced Widow

Primary Care Physician _____ Phone(___)_____

Referring Source: _____ Phone(___)_____

Employer's Name_____

Address _____

City _____ State_____ Zip Code _____

Emergency Contact Person _____
Relationship_____

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Address_____ Phone

_____

PERSON RESPONSIBLE FOR PAYING BILL (IF OTHER THAN PATIENT)

Responsible Party Name _____ Relationship to Patient _____

Address _____
City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ SS#_____

All professional services rendered by Professional Radiology, Inc./Cincinnati vein Specialist are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments, with understanding that the patient is ultimately responsible for all fees. It is customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please Read and Sign)
I hereby authorize the release of any medical information necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I hereby assign to the physician all the payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I agree to pay any balance due in full no later than 30 days of statement, unless other arrangements have been made in advance.

Signature _____ Date _____

FINANCIAL POLICY AND PATIENT FINANCIAL RESPONSIBILITY I. Patient Responsibility
You, as the patient, are ultimately responsible for all fees. We do accept insurance assignment and will file your insurance claim for you; however, you are still responsible for all co-payments or balances as required by your specific insurance plan.
You are required to bring your insurance card to each visit. Your appointment will be rescheduled if your insurance card is not available. If your insurance plan requires a referral, this **must** be obtained from your primary care physician prior to coming in to the office. It is your responsibility to obtain this referral. All co-payments and co-insurance are due at the time of service. All patients under 18 years of age must be accompanied by an adult who is responsible for any necessary copayments, co-insurance, and deductibles.

II. Acceptable Methods of Payment:
We accept cash, check, bankcard or credit card (Visa, MasterCard, Discover).

III. Insurance Benefits Verification

Pre-certification from your insurance carrier (written or verbal) is required in advance for all elective surgery. Our staff will contact your insurance plan for this approval. All co-insurance or deductibles must be paid in advance.

Signature _____ Date _____

PRIMARY INSURANCE: **SECONDARY INSURANCE:**

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Insurance Name: _____ Insurance Name: _____

Subscriber Name: _____ Subscriber Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Patients Name: _____DOB_____ Date_____

Past Surgeries *(List type and year performed)*

_____

Your Allergies to Medications *(Name medication and reaction)*

_____

Your Current Medications *(Name of medication, dose and how often)*

_____

FAMILY HISTORY

Mother: ☐ Living ☐ Deceased Age (now or__ Cause of death:_____

Father: ☐ Living ☐ Deceased Age (now or at death) ____ Cause of death:_____

Has any blood relative had any of the following *(please check and indicate relationship, i.e. mother, father, sister, brother, etc.)*

- ☐ Anesthesia problem
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ Kidney diseases
- ☐ Seizures
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No _____Packs per day # of years_____ Do you use recreational drugs? ☐ Yes ☐ No

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Date:_____ **Patient Signature:**_____
Date:_____ **MD Signature:** _____