VASCULAR AND ENDOVASCULAR INSTITUTE OF ORANGE COUNTY A MEDICAL CORPORATION
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PATIENT INFORMATION:

DATE: _____

NAME: _____ **ADDRESS:** _____

AGE: _____ **BIRTH DATE:** _____ **CITY:** _____ **STATE:** _____

SEX: M F **MARITAL STATUS:** M S W D **ZIP:** _____

HOME PHONE #: _____ **CELL #:** _____

SOCIAL SECURITY #: _____ **DRIVERS LICENSE #:** _____

EMPLOYER: _____ **WORK PHONE #:** _____

Relative not living with you: _____ **Relative's Phone #:** _____

WHO REFERRED YOU TO OUR OFFICE: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

RESPONSIBLE / INSURED PARTY INFORMATION: --- IF DIFFERENT FROM PATIENT

NAME: _____ **ADDRESS:** _____

RELATIONSHIP TO PATIENT: _____ **CITY:** _____ **STATE:** _____

ZIP: _____

HOME PHONE#: _____ **CELL #:** _____

EMPLOYER: _____ **WORK PHONE #:** _____

SOCIAL SECURITY #: _____ **DRIVER'S LICENSE #:** _____

DATE OF INJURY: _____ **WORK RELATED?** Y N **AUTO?** Y N **OTHER?** _____

INSURANCE INFORMATION MUST BE WRITTEN BELOW

PRIMARY INSURANCE: _____ **ID #:** _____ **GROUP #:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

PHONE #: _____ **SECONDARY INSURANCE:** _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize Vascular Endovascular Institute of Orange County to furnish any information needed by any insurance carrier to process any claim(s) for services rendered to the above named patient by Vascular and Endovascular Institute of Orange County and/or Dr. Gary Nishanian. I assign any benefits payable by the insurance carriers for those services to Vascular and Endovascular Institute of Orange County and/or Dr. Gary Nishanian. ***I agree to be responsible for any amount and/or supplies not covered by insurance or for the full amount if the above named patient does not have insurance.***

DATE: _____ **SIGNATURE:** _____