

CAPITAL VASCULAR SURGEONS & VEIN CENTER
3855 J STREET
SACRAMENTO, CALIFORNIA
95816
PH: (916) 733-0660
FX: (916) 733-0664

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE#: _____ WORK PHONE #: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____ MARITAL STATUS _____
S/M/D/W

SOCIAL SECURITY NUMBER: _____

EMPLOYERS NAME AND ADDRESS: _____

REFERRING PHYSICIAN: _____ ADDRESS: _____

FAMILY PHYSICIAN: _____ ADDRESS: _____

CONTACT IN CASE OF EMERGENCY – NAME AND PHONE NUMBER: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ NAME OF INSURED: _____ INSURED'S DOB: _____

IDENTIFICATION #: _____ GROUP #: _____

EMPLOYER: _____ SOCIAL SECURITY # OF INSURED: _____

SECONDARY INSURANCE: _____ NAME OF INSURED: _____ INSURED'S DOB: _____

IDENTIFICATION #: _____ GROUP #: _____

EMPLOYER: _____ SOCIAL SECURITY # OF INSURED: _____

PLEASE ALLOW RECEPTIONIST TO COPY YOUR INSURANCE CARDS. THANK YOU.

RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS

AUTHORIZATION AND RELEASE: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF ANY MEDICAL BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT. I AUTHORIZE THE RELEASE OF ANY INFORMATION REQUESTED TO SUPPORT MY CLAIM.

MEDICARE PATIENTS: I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

SIGNATURE: _____

DATE: _____