# VALLEY VASCULAR ASSOCIATES INC. MEDICAL INFORMATION SHEET

**PLEASE PRINT CLEARLY**

PATIENT NAME: ________________________________________ **PCP(Primary Care Physician)**____________________

AKA (also known as): ________________________ **D.O.B** ________/__________/____________

SSN#: ____________________________ SEX: Female □ Male□ MARITAL STATUS: S □ M □ SEP □ D □ W □

HOME ADDRESS: ____________________________________________________________________________________

CITY/STATE/ZIP CODE: ______________________________________________________________________________

HOME PHONE#:____________________________ WORK NUMBER#:______________________________

DAYTIME/CELL PHONE#: _______________________ EXT#:___________________________

EMPLOYER NAME:___________________________ OCCUPATION:__________________________________

EMPLOYER ADDRESS:________________________ CITY/STATE/ZIP CODE:__________________________

ETHNICITY: (select one)

- □ Hispanic/Latin/Spanish Origin
- □ NOT Hispanic/Latin/Spanish Origin
- □ Decline

Prefer Language: _____________________

RACE: (select one)

- □ American Indian/Alaskan Native
- □ Hispanic/Latino
- □ Asian
- □ Native Hawaiian/Pacific Islander
- □ Black or African American
- □ White
- □ Decline

PREFERRED METHOD OF COMMUNICATION: (Select one)

□ Telephone □ Mail □ E-mail

Advance Directive Type:

□ No Advance Directive □ Living Will □Durable Power of Attorney □ Do not resuscitate

***PERSON RESPONSIBLE FOR PATIENT'S FINANCIAL OBLIGATION, IF SELF, INDICATE SELF***

NAME:____________________________________

RELATIONSHIP:_____________________________ SS#:________________________ DOB:________________

HOME PHONE:______________________________ WORK PHONE#:_______________ EXT:_________________

DAYTIME/CELL PHONE:_________________________ EXT#:________________________

HOME ADDRESS (If different from Patient's address):__________________________________________________

CITY/STATE/ZIP CODE:___________________________________________________________________________

EMPLOYER NAME:__________________________ CITY/STATE/ZIP CODE:__________________________________

***IN CASE OF EMERGENCY-NAME OF RELATIVE NOT LIVING WITH YOU (local)***

PRIMARY CONTACT NAME:__________________________ RELATIONSHIP:_________________________________

HOME PHONE#:__________________________ WORK PHONE#:_______________ EXT:__________

DAYTIME/CELL PHONE#:____________________ EXT:_______________

HOME ADDRESS:__________________________________ CITY/STATE/ZIP CODE:___________________________

***PATIENT INSURANCE INFORMATION*** DO YOU HAVE INSURANCE? YES □ NO □

PRIMARY INSURACE

INSURANCE CO:_______________________________

INSURANCE PHONE#:___________________________

IF HMO GROUP NAME: __________________________

SUBSCRIBER'S DATE OF BIRTH:___________________

SUBSCRIBER'S SS#:_____________________________

POLICY#:____________________________________

GROUP#:____________________________________

EFFECTIVE DATE:______________________________

SECONDARY INSURANCE

INSURANCE CO:__________________________________

INSURANCE PHONE#:______________________________

SUBSCRIBER'S EMPLOYER NAME:_____________________

SUBSCRIBER'S DATE OF BIRTH:______________________

SUBSCRIBER'S SS#:_______________________________

POLICY#:_______________________________________

GROUP#:_______________________________________

EFFECTIVE DATE:_________________________________

***ASSIGMENT OF BENEFITS***

I hereby authorize and direct my insurance company to make payments to VALLEY VASCULAR ASSOCIATES INC., benefits allowable and otherwise payable to me and/or my dependents. I understand that I am responsible for charges not paid under this Assignment. This Authorization will remain in effect until rescinded by myself in writing. A photocopy of this may be honored.

PATIENT SIGNATURE:________________________________________ DATE:_________________________

WITNESS' SIGNATURE:_______________________________________ DATE:_________________________