

Lexington Vein and Aesthetics Center

Registration Form

(Please Print)

Patient Information									
Today's Date		Home Phone		Cell Phone			Alt. Phone		
Reason For Visit									
Last		First		Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.		Marital Status		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?			(Former Name)		Birth Date		Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address			Apt #	City		State	ZIP	Social Security	
Emergency Contact			Relationship			Phone Number			
BILLING INFORMATION									
Health Insurance Provider		ID #			Group #		Policy #		
Cardholder				Cardholder's Date of Birth					
Assignment and Release of Benefits									
<p>The above information is true to the best of my knowledge. I, the undersigned, certify that I (or my dependent) have insurance with _____ and assign directly to Lexington Vein and Aesthetics Center all insurance benefits, if any, payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Lexington Vein and Aesthetics Center to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.</p>									
Responsible Party Signature				Relationship			Date		
Employer Information									
Employer				Occupation			Employer Phone No.		
Employer Address									
Secondary Insurance (if applic.)		Subscriber's Name			Group #		Policy #		
Person responsible for Account (other than self)						Relationship			
Address (if different)						State		Zip	
Responsible Person's Home Phone			Other Phone		Date of Birth		Social Security #		
Responsible Person's Employer				Responsible Person's Employer's Address					
City		State		Zip			Phone Number		
Chose LVAC because	<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Close to Home/Work	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Hospital	<input type="checkbox"/> Other _____	