2810 W. St. Isabel St. Ste 102
Tampa, Fl. 33607
(813) 872-8480

# Vascular Action, LLC

Patient Registration

## TELL US ABOUT YOURSELF

Today's Date: _____

[ ] MALE
[ ] FEMALE

MARITAL STATUS:
[ ] S [ ] M [ ] D [ ] W

LAST NAME FIRST NAME MI

_ _ / _ _ /_ _ _ _
BIRTHDATE

PHYSICAL ADDRESS

___ ___ ___ - ___ ___ - ___ ___ ___ __
SOCIAL SECURITY NUMBER

( )
PREFERRED CONTACT NUMBER

MAILING ADDRESS

( )
ALTERNATE CONTACT NUMBER

CITY, STATE AND ZIP CODE

May we leave a detailed message? [ ] YES [ ] NO

If yes, which number: _____

NAME / LOCATION OF PHARMACY:

_____

_____
LANGUAGE

_____
RACE

[ ] Hispanic
[ ] Not Hispanic

## EMERGENCY CONTACT INFORMATION:

NAME RELATION ADDRESS CITY, STATE ZIP CODE

( ) _____
TELEPHONE NUMBER

## RESPONSIBLE PARTY

Person Responsible for Payment? [ ] Self [ ] Spouse [ ] Parent Other: _____

LAST NAME FIRST NAME MI

_ _ / _ _ /_ _ _ _
BIRTHDATE

MAILING ADDRESS

___ ___ ___ - ___ ___ - ___ ___ ___ ___
SOCIAL SECURITY NUMBER

CITY, STATE AND ZIP CODE
OUT OF STATE ADDRESS (IF APPLICABLE)

( ) _____
CONTACT NUMBER

ADDRESS_____ CITY_____STATE_____ZIP_____

PHONE_____

EMPLOYER

( ) _____ Extension: _____
WORK TELEPHONE

_____
EMAIL ADDRESS

## HEALTH INSURANCE INFORMATION

[ ] Self [ ] Spouse [ ] Other: _____

HEALTH INSURANCE COMPANY

GROUP / PLAN NUMBER

NAME INSURED PERSON

SUBSCRIBER NUMBER

## SECONDARY HEALTH INSURANCE INFORMATION

[ ] Self [ ] Spouse [ ] Other: _____

HEALTH INSURANCE COMPANY

GROUP / PLAN NUMBER

NAME INSURED PERSON

SUBSCRIBER NUMBER

IF YOU ARE COVERED BY MEDICARE, PLEASE COMPLETE THE FOLLOWING

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: For services beginning _____ I authorize any holder of medical or other medical information about me to release to the Social Security Administration and Health Care Financial Administration or its intermediaries or carriers , to other billing agents of VASCULAR ACTION any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits, either to myself or to the party who accepts assignment.

PATIENT SIGNATURE_____

AUTHORIZATION: I authorize release of any payment or medical information necessary to process my claim. I request payment of insurance benefits to any, member of VASCULAR ACTION, LLC. I understand I am financially responsible for charges not covered by this authorization, including transportation services. A photostatic copy will be deemed as good as the original.

SIGNED_____