Valley Endovascular Associates

One Webster Avenue, Suite 307,
Poughkeepsie, NY 12601
845-483-5352 FAX 845-485-3804

PATIENT REGISTRATION

Patient Name _____ Birth date_____ Sex_____

Address_____ City _____ State _____ Zip _____

Home Work

SS # _____ Phone #_____ Phone # _____

Email _____

Employer _____

Address_____ City _____ State _____ Zip _____

Person Responsible Relationship

For Payment _____ Phone # _____ to Patient _____

Referring Physician _____ Phone # _____

Physician Address _____ City _____ State _____ Zip _____

Were you injured At Work ( ) In a Car Accident ( ) ?

INSURANCE INFORMATION

Medicare ID # _____ Medicaid ID # _____

Insurance Company Name _____Auth # _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ ID # _____ Group # _____

Additional Coverage

Insurance Company Name _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ ID # _____ Group # _____

I verify the accuracy of the above information and authorize the release of medical information necessary to process this claim. I authorize direct payment of above services. I am aware that I am responsible for any co-payment, deductible or balances not covered by my insurance carrier. I further understand that there is a charge for copies of films.

SIGNATURE_____DATE_____

For Office Use Only

PATIENT ID # _____

SP _____ PROF CRTSY _____ HOSP EMP _____ WC _____ NF _____ LB _____

INSURANCE INFORMATION _____

GROUP	PROC/QUANTITY	PROVIDER	LOC	SVC DATE	DIAGNOSIS	REF PHYS