Vein Treatment Institute of Bucks County

David N. Brotman, M.D.

PATIENT REGISTRATION INFORMATION

Is your condition a result of a work injury? YES NO An auto accident? YES NO Date of Injury ________

PATIENT'S PERSONAL INFORMATION Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ M ☐ F

Name: ______________________ (Last) ______________________ (First) ______ (MI)

Street Address: ______________________ (Apt #) ______ City: ____________ State: ____ Zip ______

Home Phone: (____) ________ Work Phone: (____) ____________ SS# ______ - ____ - ______ DOB __/__/__

Employer/School ______________________ Address: ______________________

Spouse's Name: ______________________ (Last) ______________________ (First) ______ (MI)

Home Phone: (____) ________ Work Phone: (____) ____________ SS# ______ - ____ - ______ DOB __/__/__

Spouse's Employer/School ______________________ Address: ______________________

PATIENT'S INSURANCE INFORMATION *Please present insurance cards to receptionist*

(If Self or Spouse is checked as insured, just list Insurance Company and ID Number and Group Number)

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

PRIMARY INSURANCE COMPANY'S NAME: ______________________

Insurance Address: ______________________ City: ____________ State: ______ Zip: ______

Name of Insured: ______________________ DOB __/__/__ SS# ____ - ____ - ______

Insurance ID Number: ______________________ Group Number: ____________

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE COMPANY'S NAME: ______________________

Insurance Address: ______________________ City: ____________ State: ______ Zip: ______

Name of Insured: ______________________ DOB __/__/__ SS# ____ - ____ - ______

Insurance ID Number: ______________________ Group Number: ____________

Check if appropriate: ☐ Medigap Policy ☐ Retiree Coverage

PATIENT'S REFERRAL INFORMATION

Referred By: ______________________ If referred by a friend, may we thank him or her? YES NO

EMERGENCY CONTACT

Name of person not living with you: Relationship:

Home Phone: (____) ____________________ Work Phone: (____) ____________________ Cell Phone: (____) ______________________

Assignment of Benefits and Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Langhorne Surgical Group, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection ,and reasonable attorney's fees. I further agree that a photocopy of this agreement shall be as valid as the original. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Langhorne Surgical Group for any service furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

Date: __________________ Your Signature: ____