NEW PATIENT REGISTRATION FORM

PLEASE DO NOT LEAVE ANY BLANKS.

Patient's name: ______________________________ Birth date: ______________ Age: __________

Social Security Number: ______________________________ Sex: M F Marital Status: S M W D

Home Phone: ______________________________ Cell Phone: ______________________________

Home Address: ____
(street number/name) (city) (state) (zip)

Occupation: ____

Employment:(Please circle one) FT PT SELF RETIRED NOT EMPLOYED ACTIVE MILITARY DUTY OTHER

Employer: ______________________________ Work phone: ______________________________
(If retired, please indicate previous employer)

Employer's address: ____
(street number/name) (city) (state) (zip)

Spouse: ____

Referred by: ______________________________ Family Physician: ______________________________

Reason for Visit: ____

In Case of Emergency/Alternate Contact/relation/phone number: ______________________________

Insurance Information

Primary Insurance: ____

Policy #: ____________________ Group#: ____________________ Subscriber: ____________________

Subscriber's date of birth: ______________________________ Subscriber's SSN: ______________________________

Subscriber's employer: ____

Employer's address: ____
(street name/number) (city) (state) (zip)

Secondary Insurance: ____

Policy #: ____________________ Group #: ____________________ Subscriber: ____________________

Subscriber's date of birth: ______________________________ Subscriber's SSN: ______________________________

Subscriber's employer: ____

Employer's address: ____
(street name/number) (city) (state) (zip)

PLEASE HAVE YOUR INSURANCE CARDS AVAILABLE FOR PHOTOCOPYING. ALL CHARGES ARE DUE AT THE TIME OF THE SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Over

Patient Authorization

I authorize payment of medical benefits to Vascular Surgery Associates, L.L.C. ("VSA") for services provided. I understand that I personally guarantee payment for all costs of services rendered. In addition, and if payment in full is not received within 120 days of date of service, I agree to pay a finance charge of 1 ½ per month (18% per year) plus all costs of collection and attorneys fees of 25% of the total outstanding balance then due. Further I agree that if court action becomes necessary, I consent to the personal jurisdiction and venue of Harford County, MD.

I authorize the release of any medical information necessary in coordination of my medical treatment care.

Signed: ______________________________ Date: ______________

(Patient's or authorized person's signature)

ACKNOWLEDGEMENT

I received a copy of Vascular Surgery Associates' Notice of Privacy Practices.

Signature: ______________________________ Date: ______________

May we leave a detailed message on your answering machine regarding personal health information, verifying appointment times, or to change an appointment? no yes

May we leave a detailed message with another family member in your household regarding personal health information, verifying appointment times, or to change an appointment? no yes

May we leave a detailed message on your voice-mail either at work or on a cell phone regarding personal health information, verifying appointment times, or to change an appointment? no yes