



Vein Treatment Specialists, PC

Dr. Bob Dupper, MD, Phlebologist.
Specializing in outpatient treatment of varicose vein disease.

Patient Registration Information

PATIENT NAME: _____ TODAY'S DATE: _____
Last First Middle Initial

STREET ADDRESS: _____ P.O. BOX _____

CITY, STATE, ZIP: _____

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____

CELL PHONE: (_____) _____ E-MAIL: _____

By which method(s) would you prefer to be contacted? Please check above preference(s).

DATE OF BIRTH: ____/____/____ AGE: _____ SEX: Female Male

MARITAL STATUS: Single Married Divorced Widowed Separated

SOCIAL SECURITY NUMBER: _____ - _____ - _____

EMPLOYMENT STATUS: Full-Time Part-Time Self-Employed Retired Unemployed

PLACE OF EMPLOYMENT & ADDRESS: _____

OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE: (_____) _____

RELATIONSHIP TO YOU: _____

PRIMARY PHYSICIAN: _____ CLINIC: _____

How would you like to be reminded for your upcoming appointment?: (please check one)

Phone Call: _____ **Text Message:** _____ **Email:** _____

How did you hear about Vein Treatment Specialists, PC?

- LOVELAND REPORTER HERALD LOVELAND CONNECTION INTERNET FRIEND _____
- BILLBOARD DEX YELLOWPAGES NAMES AND NUMEBRS PHONE BOOK VALPAK
- FORTCOLLINS COLORADOAN WINDSOR BEACON WINDSOR NOW GREELEY TRIBUNE
- HEALTH CENTRAL NEWSLETTER PHYSICIAN AD CARD IN GLENWOOD SPRINGS
- Other _____



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PERSON RESPONSIBLE FOR BILL: (SELF ____ OTHER ____) _____

RELATIONSHIP TO YOU: _____

ADDRESS (IF DIFFERENT FROM YOU) _____

PHONE: _____

HEALTH INSURANCE: _____

SUBSCRIBER: (SELF ____ OTHER ____) _____

SUBSCRIBER DATE OF BIRTH: ____/____/____ SSN: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

EMPLOYER THROUGH WHICH PROVIDED: _____

EMPLOYER ADDRESS: _____

DO YOU KNOW WHAT YOUR DEDUCTIBLE IS? _____ COPAY: _____

OTHER (SECONDARY) HEALTH INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

EMPLOYER THROUGH WHICH PROVIDED: _____

EMPLOYER ADDRESS: _____

DO YOU KNOW WHAT YOUR DEDUCTIBLE IS? _____ COPAY: _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE (INCLUDING COLLECTION FEES) NOT PAID TO VEIN TREATMENT SPECIALISTS, P.C. BY MY HEALTH INSURANCE. _____

I AUTHORIZE VEIN TREATMENT SPECIALISTS, P.C. TO RELEASE ANY INFORMATION REQUIRED TO PROCESS HEALTH INSURANCE CLAIMS FOR ALL SERVICES RENDERED TO ME. _____

SELF PAY AND PREVIOUS BALANCE AMOUNTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE. INSURANCE COPAYS ARE MANDATED BY YOUR HEALTH INSURANCE COMPANY AND MUST BE PAID AT EACH VISIT _____

I AUTHORIZE MY HEALTH BENEFITS TO BE PAID DIRECTLY TO VEIN TREATMENT SPECIALISTS, P.C. I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE AND MEDICAL BENEFITS BE MADE PAYABLE TO VEIN TREATMENT SPECIALISTS, P.C. ON MY BEHALF FOR SERVICES RENDERED TO ME. _____

I AUTHORIZE THE HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE ANY INFORMATION TO CENTERS FOR MEDICARE AND MEDICAL SERVICES, IT AGENTS, MY INSURANCE CARRIERS OR OTHER ENTITIES AS NEEDED TO DETERMINE BENEFITS OR THE BENEFITS OF MY DEPENDENTS OR MYSELF. I AUTHORIZE VEIN TREATMENT SPECIALISTS, P.C. TO RELEASE INFORMATION CONCERNING DIAGNOSIS AND TREATMENT TO MY PRIMARY CARE OR REFERRING PHYSICIAN AFTER EACH VISIT. _____

PATIENT / GUARDIAN: _____ DATE: _____