P. Michael Davis, MD FACS
Michael S. Conners, MD, FACS
James W. McNeil, MD, FACS

PATIENT REGISTRATION FORM

CVT
SURGICAL CENTER
VEIN THERAPY CENTER
VASCULAR LAB

Brandie Henry, PA-C
Samantha Tiblier, FNP-C
Adrienne Castille, PA-C
Taylor Brown, PA-C
Lara Lauter, PA-C

PERSONAL INFORMATION

_____ Patient Name (Last, First, MI)
_____ Street Address or PO Box
_____ City, State Zip Code

_____ Gender
_____/_____/_____ Date of Birth
_____ Social Sec. Number
_____ Marital Status
_____ Home Telephone
_____ Mobile Telephone

_____ Email Address
_____ Referring Physician
_____ Primary Care Physician

_____ Current Employer or Company Retired From
_____ Employer City. State
_____ Employer Telephone
_____ Year Retired

_____ Spouse's Name
___/___/___ Spouse's DOB
_____ Spouse's Telephone
_____ Spouse's Employer

_____ Emergency Contact (Relative Not At Same Address)
_____ Emergency Telephone
_____ Relationship to Emergency Contact

INSURANCE INFORMATION *(Please Provide Copies of Cards at Registration)*

PRIMARY PLAN

_____ Carrier Name
_____ Subscriber ID
_____ Group ID
_____ Subscriber Name
____/____/____ Subscriber DOB

SECONDARY PLAN

_____ Carrier Name
_____ Subscriber ID
_____ Group ID
_____ Subscriber Name
____/____/____ Subscriber DOB

OTHER PLAN

_____ Carrier Name
_____ Subscriber ID
_____ Group ID
_____ Subscriber Name
____/____/____ Subscriber DOB

ASSIGNMENT / MEDICAL RECORDS RELEASE AUTHORIZATION / CONSENT TO CONTACT

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to CVT Surgical Center, AMC or CVT Vascular Lab, Inc. for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services or other insurance company, any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for all charges at all times and authorize CVT Surgical Center, AMC or CVT Vascular Lab, Inc. and its agents, including attorneys and collection agencies acting on its behalf, to contact me regarding my outstanding balances through various means of communication including, but not limited to, cell phone, landline, digital delivery via texts to SMS-enabled mobile number(s) and email address(s) on file, auto-dialer systems and pre-recorded voice messages.

_____ Signature of Patient or Authorized Representative
_____/_____/_____ Date Signed
_____ Written Name of Authorized Representative (if other than Patient)