



Albuquerque Vein & Laser Institute New Patient Intake Form

Patient Information

Name: _____ Date of Birth: _____ Gender: F M

Social Security #: _____ Driver's License #: _____ State: _____

Home Address: _____

City/State/Zip: _____

Contact Numbers- Home: (____) _____ Work: (____) _____ Cell: (____) _____

Employer: _____ Employer's address: _____

Spouse Name: _____

Spouse Employer: _____

Referring Physician: _____

Primary Care Physician: _____

Person to Contact in Case of Emergency: _____

Relation to Patient: _____ Telephone #: _____

How did you hear of our practice? Referring Doctor Friend/Family Member Internet

Yellow Pages Print Ad (where) _____ Other _____

Health Insurance Information

Primary Insurance: _____ Policy Holder's Name: _____

Address: _____ Date of birth: _____

Secondary Insurance: _____ Policy holder's name: _____

Address: _____ Date of birth: _____

Other Insurance: _____ Policy holder's name: _____

Address: _____ Date of birth: _____

Authorization: I hereby authorize my insurance carriers to pay benefits directly to Albuquerque Vein & Laser Institute. I understand that I am responsible to pay for any services not covered by my insurance. I also authorize release of pertinent medical information to my insurances carriers and the above-named physicians.

Signature

Date