

VASCULAR AND ENDOVASCULAR CENTER OF WNY

PATIENT REGISTRATION FORM

Joseph M. Anain, Sr., MD FACS
Paul M. Anain, MD FACS
Sara L. Eddy, MS, RPA-C

Account # _____

Date of Birth: _____

Patient Name: _____

Male: _____ Female: _____

Street: _____

City: _____

State: _____ Zip Code: _____

Home Phone# _____

Social Security # _____

Referring MD: _____

Primary MD: _____

Pharmacy: _____

(Please include Pharmacy name, address, and phone number)

Reason for visit: _____

*****EMPLOYMENT INFORMATION*****

Employer: _____

Address: _____

Work Phone: _____ Retirement Date: _____

*****INSURANCE INFORMATION*****

Primary Insurance: _____

ID# _____ Group #: _____

Subscriber: _____ DOB: _____

Effective Date: _____ Relationship to Patient: _____

Secondary Insurance (if applicable): _____

ID# _____ Group# _____

Subscriber: _____ DOB: _____

Effective Date: _____ Relationship to Patient: _____

WORKER'S COMPENSATION/NO FAULT INFORMATION (IF APPLICABLE)

Carrier: _____ Claim# _____

Address: _____ Date of Injury: _____

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In case of emergency, please contact:

Name: _____ Phone #: _____

Relationship to patient: _____

******PLEASE COMPLETE OTHER SIDE OF FORM******

Vascular and Endovascular Center of WNY
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AUTHORIZATION

Please remember that insurance is considered a method of reimbursing the patient for fees payable to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay a deductible amount, co-insurance, or any other balance not paid by your insurance.

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carriers, any information required to process any Medical claims. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claims.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, (including Medicare, private insurance, and other health plans), to the practice of Vascular and Endovascular Center of WNY. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges whether or not paid by said insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS (IF THEY ARE NOT COVERED BY YOUR INSURANCE) AND CO-PAYS BE PAID AT THE CONCLUSION OF EACH VISIT.

I hereby give my permission to Joseph M. Anain, Sr., MD/Paul M. Anain, MD/Sara Eddy, MS, RPA-C to administer treatment and to perform such procedures as may be necessary in the diagnosis and/or treatment of my condition.

DATE: _____ SIGNATURE: _____

THANK YOU FOR YOUR COOPERATION