David H. Bellamah, M.D., FACS
Bellamah Vein Center

PATIENT REGISTRATION FORM (PLEASE FILL OUT WITH BLACK/BLUE PEN)

PATIENT INFORMATION

NAME (LAST, FIRST, M.I.): _____

BIRTHDATE: _____ SEX: Male XXX-XX-_____

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED / PARTNER

PRIMARY PHONE: _____ SECONDARY PHONE: _____

ADDRESS: _____

EMERGENCY CONTACT (NAME/RELATION **AND** PHONE #): _____

PRIMARY CARE PHYSICIAN? _____

REFERRING PHYSICIAN? _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____

POLICY ID #: _____ GROUP #: _____

SUBSCRIBER NAME: _____ DOB: _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: _____

POLICY ID #: _____ GROUP #: _____

SUBSCRIBER NAME: _____ DOB: _____

CONSENT

I CERTIFY THAT I, AND/OR MY DEPENDENT(S), HAVE INSURANCE COVERAGE WITH THE ABOVE LISTED INSURANCE COMPANY (IES) AND ASSIGN DIRECTLY TO DR. BELLAMAH ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. THE ABOVE-NAMED PHYSICIAN MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY (IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OF THE BENEFITS PAYALBE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

DATE