Triangle Vein Clinic

Victor A. Medina, M.D., F.A.C.S.

Patient Registration (page 1 of 1)

PATIENT INFORMATION

ACCOUNT # _____

PATIENT NAME _____ AGE _____ SEX _____ BIRTH DATE __ / ___ / _____

STREET _____ CITY _____ STATE ____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____ BUSINESS PHONE _____

OCCUPATION / RETIRED _____ SOCIAL SECURITY NO ____ - ___ -_____

REFERRING DOCTOR _____

PRIMARY CARE PHYSICIAN/ADDRESS _____ PHONE _____

WOULD YOU LIKE NOTES SENT TO YOUR PRIMARY CARE PHYSICIAN? ☐ YES ☐ NO

PHARMACY NAME / ADDRESS _____ PHONE _____

SPOUSE'S NAME _____ SOCIAL SECURITY NO ___ - ___ -_____ BIRTH DATE ___ /____ / ____

PHONE _____ SPOUSE'S EMPLOYER NAME _____

EMPLOYER ADDRESS _____ BUSINESS PHONE _____

IN CASE OF EMERGENCY, NOTIFY _____

RELATIONSHIP _____ PHONE _____

ADDRESS _____

INSURANCE INFORMATION

INSURANCE NAME _____

PLAN _____ SUBSCRIBER NAME _____

ID NUMBER _____ GROUP NAME/GROUP NO _____

SIGNATURE _____ DATE _____

INSURANCE NAME _____

PLAN _____ SUBSCRIBER NAME _____

ID NUMBER _____ GROUP NAME/GROUP NO _____

SIGNATURE _____ DATE _____