



# Southern Arizona Laser & Vein Institute

6422 East Speedway Boulevard - Suite 150 - Tucson, Arizona 85710  
Phone: (520) 318-3004 Fax: (520) 318-3061 www.SALVI-Tucson.com

## PATIENT REGISTRATION FORM

Account # \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
Last First Legal Nickname MI

Is this your legal name? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, what is your legal name? \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorce \_\_\_\_\_ Widow \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ PO Box: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Your Employer: \_\_\_\_\_ Phone# \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Physician (if different) \_\_\_\_\_ Phone #: \_\_\_\_\_

## INSURANCE INFORMATION

**Are you covered by health insurance?** Yes \_\_\_\_\_ No \_\_\_\_\_ **If No, please make payment arrangements with our business office.**

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ Copay \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ Copay \_\_\_\_\_

If this visit related to an at work injury? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, Employer at time of injury \_\_\_\_\_

Date of Injury \_\_\_\_\_ Insurance Info \_\_\_\_\_ Claim # \_\_\_\_\_

## EMERGENCY CONTACT

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Date of Birth \_\_\_\_\_

### PLEASE COMPLETE AND SIGN THIS RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS

"I hereby authorize Southern Arizona Laser & Vein Institute to release to or to request from any insurance company, other physician or hospital, any information including the diagnosis and records of any treatment or examination rendered to me during surgical care. This includes any financial information. This information may be faxed. I also authorize and request my insurance companies to pay directly to the above named corporation the amount due on any pending insurance claim for medical and/or surgical treatment or service. I also understand that if it becomes necessary to refer my account to collections, I will be liable for the reasonable collection fees and court costs expended therein." I understand that there is a \$25 pre-paid fee for all disability forms filled out by the physician. The physicians reserve the right to charge interest on unpaid accounts.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Or parent/guardian if patient is a minor) "Duplicate of this release & assignment is as valid as the original"