JEFFREY T. PREM, M.D. M. TODD MILLER, M.D. BRETT A. BUTLER, M.D.

REGIONALVASCULAR & VEIN INSTITUTE

GENERAL • ENDOSCOPIC • LAPAROSCOPIC • VASCULAR

400 Medical Park Drive, Suite 203
Dover, Ohio 44622
Phone: 330-602-7702

6046 Whipple Avenue NW,
Suite 103
Canton, Ohio 44720
Phone: 330-588-8900

PATIENT'S NAME: _____ **DATE:** _____
FIRST MIDDLE LAST

ADDRESS: _____
CITY STATE ZIP

SOCIAL SECURITY#: _____ **BIRTH DATE:** _____ **AGE:** _____ **SEX:** _____

MARITAL STATUS: S M W D

HOME PHONE: _____ **EMERGENCY CONTACT NUMBER:** _____

PATIENT'S EMPLOYER: _____ **PHONE:** _____

EMPLOYER'S ADDRESS: _____
CITY STATE ZIP

SPOUSE/GUARANTOR: _____

SOCIAL SECURITY#: _____ **BIRTH DATE:** _____

EMPLOYER: _____ **PHONE:** _____

EMPLOYER'S ADDRESS: _____
CITY STATE ZIP

COMPLAINT: _____ *Is this work related?* _____**YES** _____**NO**

REFERRING DOCTOR: _____ **PHONE:** _____

FAMILY DOCTOR: _____ **PHONE:** _____

PRIMARY INSURANCE	**OTHER INSURANCE** *Medicare Crossover?* _____**YES** _____**NO**
NAME: _____	**NAME:** _____
ADDRESS: _____	**ADDRESS:** _____
CITY, STATE, ZIP: _____	**CITY, STATE, ZIP:** _____
PHONE: _____	**PHONE:** _____
SUBSCRIBER'S NAME: _____	**SUBSCRIBER'S NAME:** _____
POLICY #: _____	**POLICY #:** _____
GROUP NAME/NUMBER: _____	**GROUP NAME/NUMBER:** _____

IN ORDER TO SUBMIT AN INSURANCE CLAIM FOR SERVICES RENDERED, WE MUST HAVE YOUR AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE CARRIER.

I verify the accuracy of the above information and hereby authorize the release of any information necessary to process a claim with my insurance company. I authorize payment of medical benefits paid directly to Regional Vascular & Vein Institute. **I understand that I am financially responsible for any charges incurred regardless of insurance coverage.** This signature is valid until revoked by me in writing.

SIGNATURE: _____ **DATE:** _____

Office visits are due and payable at the time of service unless you have Medicare or we participate with your insurance plan. If we do participate with your carrier, you are responsible for your co-payment at the time of service. If your insurance requires a written authorization from your primary care physician, please provide this prior to your appointment

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