ADVANCED VEIN & VASCULAR CENTER, INC.

744 W. Lancaster Avenue ~ Suite 225 ~ Wayne, PA 19087
Telephone: 610-687-5347 ~ Fax: 610-687-1450

Last Name:_____ First Name:_____ Middle:_____

Gender: M F Date of Birth: _____ Married Single Divorced Widowed Domestic Partner

Mailing Address: _____

City: _____ State: _____ Zip Code:_____

Race: _____ Ethnicity: _____ Language:_____

□ Prefer not to answer □ Prefer not to answer □ Prefer not to answer

To respect your privacy, please list only the phone numbers that we may call and leave messages:

Home:_____ Work: _____ Cell: _____

Emergency Contact: _____ Relationship: _____ Phone No: _____

Patient Email: _____

Interest in Patient Portal: □ yes □ no Information via email: □ yes □ no

Occupation: _____ Employer: _____

Referring Physician Name & Phone Number/Address: _____

_____

Primary Physician Name & Phone Number/Address: _____

_____

How did you find/hear about us? Physician Referral Friend mainlinelegs.com Radio Other:_____

An insurance card will be required for each visit if you would like us to bill your participating insurance.
If you are not the responsible party (i.e.: you are insured under the plan of a spouse/parent) please list their information below:

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to Insured: _____ Additional Insurance Information: _____

_____

***HAS YOUR INSURANCE CHANGED IN THE PAST 6 MONTHS:** __YES __ NO . If it has, you may be subject to a pre-existing condition clause, if you had previously sought a consult on same condition. In this case, you may need to postpone treatment, or recognize you could be held responsible to pay and not your insurance company.

Patient Signature: _____ Date:_____

PLEASE READ AND SIGN REVERSE SIDE.