Sandman Center for Veins

Melissa Sandman, M.D.

Patient Demographic Form

Last Name_____ **First Name**_____ **MI**_____

Birth date:_____ **SS#**_____ **Marital Status**_____ **Race**_____

Address_____ **E-Mail**_____

City_____ **ST**_____ **Zip**_____

Home (____)_____ **Work (____)**_____ **Cell (____)**_____

Emergency Contact_____ **Relation**_____ **Phone (____)**_____

I AGREE TO BE CONTACTED AT THE NUMBERS ABOVE FOR EMERGENCY REASONS INCLUDING THE POSSIBILITY OF CHANGING OR CONFIRMING MY APPOINTMENT(S). _____Initials

Primary Care Doctor _____ **Referring Doctor** _____

EMPLOYER_____

Employer Address_____

City_____ **ST**_____ **Zip**_____

Phone (____)_____ **Ext**_____ **Fax (____)**_____

INSURANCE COMPANY NAME_____

Policy Holder's Name_____ **Date of Birth**_____ **SS#**_____

Insurance Company Address_____

Policy Holder's Employer_____ **Group Number**_____ **I.D./Policy#**_____

My Co-Payment per office visit is_____ **Patient Signature**_____

SECONDARY INSURANCE COMPANY NAME_____

Policy Holder's Name_____ **Date of Birth**_____ **SS#**_____

Insurance Company Address_____

Policy Holder's Employer_____ **Group Number**_____ **I.D./Policy#**_____

My Co-Payment per office visit is_____ **Patient Signature**_____

AUTHORIZATION:

Authorization to pay benefits to physician and to release information: I hereby authorize payment directly to the physician of surgical and/or medical benefits if any otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the physician to release information acquired in the course of treatment necessary to process claims. I understand that I am financially responsible for all charges, whether or not covered by my insurance company. Payment is due at the time service is rendered unless insurance is billed. I permit payment directly to Sandman Center for Veins for any benefits due for services rendered. I delegate Sandman Center for Veins to appeal any charges on my behalf. In the event of default, I agree to pay all costs of collection including reasonable attorney fees and court costs.

Patient Signature_____ **Date:**_____