Vascular Diagnostics of LI PC

46 Little East Neck Road

Babylon, NY 11702
Phone: 631-321-6704 Fax: 516-7659142

Patient Data Form

PLEASE PRINT CLEARLY Account #_____

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Street City State Zip Code

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Sex: Male Female Marital Status: S M W D Sep SS # _____

Employer:

_____

_____

_____ (enter company name and address)

IN CASE OF EMERGENCY, please contact: _____

Name Relationship

_____

Address Phone

Responsible Party for Bill: _____

Name Relationship

Referring Doctor: _____

Name Phone

_____

Address

I certify that the information given on the front and back of this sheet is accurate and I authorize the release of any medical information necessary to process the claims for payment. I authorize payment of medical benefits to Vascular Diagnostics of LI PC for professional services rendered. In the event that my insurance company refuses payment for the professional services rendered, I understand and agree

that regardless of my insurance status, I will be directly and ultimately responsible for the full/partial balance on my account. I have read and understood and will comply with the above statements.

Signature of Patient/Guarantor/Authorized Party Date of Signature

Insurance Information

Required Information: Carrier Name

Carrier Address

Subscriber Name

Policy Number

Group Number

Group Name

Effective Date

Relationship of patient to subscriber

Patient claim form required for submission? Yes No

Participating plan of Doctor? Yes No

Verified current coverage with carrier? Yes No

Make photocopies of all insurance cards (front and back). Attach to this sheet.