1835 W. County Rd C, Suite 80, Roseville, MN 55113

P: 651-797-6880 F: 651-797-6881

info@spartzvein.com spartzvein.com

Demographic Information

Contact Information ***(office use) MRN: ________________________ CMRN: ______________***

First Name: ___________________________ Last Name: ______________________________ Mid Int: _____ Date: __________

DOB: ___/___/____ Sex: M ☐ F ☐ ___ Single ___ Married ___ Divorced ___ Widowed SS# ______________________

Address: ____

City: _________________________________ State: _____ Zip Code: _____________ Email: _______________________________

Home Phone: _____________________ Cell Phone: _________________ Work Phone: ________________

Which phone is primary: _____home ____ cell ____ work Do we have permission to leave a detailed message on all phones? _____yes _____no ________________ phone only initials __________

Employment status: ___ FT ___ PT ___Unemployed ____ Homemaker ____ Self-employed ___ Other: ________________________

Race: __________________________

Ethnicity: __________________________ 1st language: ________________________ 2nd language: _______________________

Emergency Contact Information

Name: ____ Phone: ________________________

Relationship to you: _____________________________

Referring Physician Information

Name of referring Physician: ____ Clinic: ___________________________________

Address: ___________________________________Phone: __________________________ Fax: ________________________

Insurance Information

How will you be paying for your medical services? ☐ Insurance ☐ Self Pay ☐ Other _______________

PRIMARY INSURANCE:

Insurance Name: _________________________________ Subscriber: _________________________________ DOB: __________

Group#: ____________________________ Member Id: ____

SECONDARY INSURANCE:

Insurance Name: _________________________________ Subscriber: _________________________________ DOB: __________

Group#: ____________________________ Member Id: ____

How did you hear about Spartz Vein Clinic? ____

I hereby authorize my insurance benefits to be paid directly to Spartz Vein clinic or representative of Spartz Vein clinic. I understand that I am responsible for all charges incurred for my care and I am responsible to pay for non-covered services. I also authorize the release of pertinent medical information necessary to process my insurance claims.

Signature: ____ Date: _______________________________