OC VEIN CARE
PATIENT REGISTRATION INFORMATION

Welcome to our office!

Name: _____ _____ _____
Last First Middle
Birth date: _____ Age: ____ Social Sec. #: _____ Driver's Lic#:_____

Address: _____ City: _____ State: ____ Zip: _____

Home ph: (____) _____ Work Ph: (____) _____ Cell Ph: (____) _____

Emergency contact Name & Number: _____

Employer: _____ Occupation: _____

Email: _____ How did you hear about us? _____

May we send you updates on our services? YES or NO

Do you prefer to be contacted by phone, mail or email? _____
Check here if you do not want to be contacted at all _____

INSURANCE INFORMATION

PRIMARY Insurance company's name:_____

Address: _____ City: _____ State: _____ Zip:_____

Insurance ID number: _____ Group number:_____

SECONDARY Insurance company's name: _____

Address: _____ City: _____ State: _____ Zip:_____

Insurance ID number: _____ Group number: _____

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Dr. Maraya Altuwaijri, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.
*A twenty-dollar fee will be assessed to your account if your bank returns your check to us.

Signature: _____ Date:_____