

**David H. Bellamah, M.D., FACS**

Bellamah Vein Center

**PATIENT REGISTRATION FORM (PLEASE FILL OUT WITH BLACK/BLUE PEN)**

**PATIENT INFORMATION**

NAME (LAST, FIRST, M.I.): \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SEX: \_\_\_\_\_ SS#: XXX-XX-\_\_\_\_\_

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED / PARTNER

PRIMARY PHONE: \_\_\_\_\_ SECONDARY PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT (NAME/RELATION **AND** PHONE #): \_\_\_\_\_

PRIMARY CARE PHYSICIAN? \_\_\_\_\_

REFERRING PHYSICIAN? \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE INFORMATION**

INSURANCE COMPANY: \_\_\_\_\_

POLICY ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

INSURANCE COMPANY: \_\_\_\_\_

POLICY ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**CONSENT**

I CERTIFY THAT I, AND/OR MY DEPENDENT(S), HAVE INSURANCE COVERAGE WITH THE ABOVE LISTED INSURANCE COMPANY (IES) AND ASSIGN DIRECTLY TO DR. BELLAMAH ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. THE ABOVE-NAMED PHYSICIAN MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY (IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OF THE BENEFITS PAYALBE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

\_\_\_\_\_  
DATE