

# Midwest Vein & Vascular Center Patient Registration Form

Please confirm the following information:

If incorrect or missing, please write corrections here:

First Name \_\_\_\_\_  Correct \_\_\_\_\_

Last Name \_\_\_\_\_  \_\_\_\_\_

Please place a 1, 2, or 3 next to each phone number to indicate the order in which you would like us to contact you to confirm your appointments.

Home Phone# \_\_\_\_\_  \_\_\_\_\_

Work Phone# \_\_\_\_\_  \_\_\_\_\_

Cell Phone# \_\_\_\_\_  \_\_\_\_\_

e-mail \_\_\_\_\_  \_\_\_\_\_

I would like to receive emails from MVC with news regarding vein care and offers for treatment.

I prefer appointment confirmations by:  text to my cell  email  telephone number(s) above

It is o.k. to leave a voice message at the following numbers. *(please circle)* Home Work Cell None

It is o.k. to leave a message with a person at the following numbers. *(please circle)* Home Work Cell None

By initialing here \_\_\_\_\_, I affirm that I was given a copy of the HIPAA law explanation.

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Gender: Male Female (circle one)

Home Address: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Name of Person to contact in an Emergency: \_\_\_\_\_

Their Phone#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Your relationship: \_\_\_\_\_

Whom may we thank for referring you to our practice, or how did you learn about our services? \_\_\_\_\_