



Khateeb Vein Center

3235 Trawood
El Paso, TX 79936

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
 Last Name First Name Middle Initial
 Address _____ E-mail _____
 City _____ State _____ Zip _____
 Sex M F Age _____ Birthdate _____ Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
 Patient Employer/School _____ Occupation _____
 Employer/School Address _____ Employer/School Phone (____) _____
 Whom may we thank for referring you? _____
 In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____ Last Name First Name Middle Initial
 Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
 Address (If different from patient's) _____ Phone (____) _____
 City _____ State _____ Zip _____
 Person Responsible Employed by _____ Occupation _____
 Business Address _____ Business Phone (____) _____
 Insurance Company _____
 Contract # _____ Group # _____ Subscriber # _____
 Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No
 Subscriber Name _____ Birthdate _____ Relation to Patient _____
 Address (If different from patient's) _____ Phone (____) _____
 City _____ State _____ Zip _____
 Subscriber Employed by _____ Business Phone (____) _____
 Insurance Company _____ Soc. Sec. # _____
 Contract # _____ Group # _____ Subscriber # _____
 Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
 Name of Insurance Company(ies)
 Dr. _____ 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 or the benefits payable 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

 Relationship to Patient