HIGHLAND PARK SURGICAL ASSOCIATES
AFFILIATED VASCULAR LAB

Last Name:_____First Name:_____M.I._____
(Please Print)

Address:_____

City:_____ State:_____ Zip:_____

Home Phone: (_____)_____-_____ Cell Phone:(_____)_____-_____

Work Phone: (_____)_____-_____ X_____ Sex: Male Female

Date of Birth: ____/____/_____ Age: _____ SS#: _____-_____-_____

Marital Status: S M D W Spouse's Name:_____DOB:___/___/____

Patient Employer:_____
Patient Occupation:_____

Emergency Contact Name:_____Phone: (_____)_____-_____
Relationship:_____

* Referring Doctor: (Last Name)_____ (First Name)_____
Address: _____
Phone: (_____)_____-_____

Primary Doctor: (Last Name)Dr._____ (First Name)_____

Please Circle your Doctor: Dr. Curtiss Dr. Rosen Dr. Tutela

Primary Insurance Carrier:_____
Insurance Id#: _____ Group #:_____
Secondary Insurance Carrier:_____
Insurance Id#: _____ Group #:_____

* Please give insurance cards to front desk along with any co-pays and/or referrals
* Failure to provide this information may result in an insurance denial and make you responsible for full payment

I authorize payment of benefits on my behalf to HPSA for services provided to me. I also authorize any holder of medical information about me to release to those parties who are financially liable for my medical care any information needed to determine these benefits and the benefits for any related services.

_____ _____
Signature of Patient or Representative Date