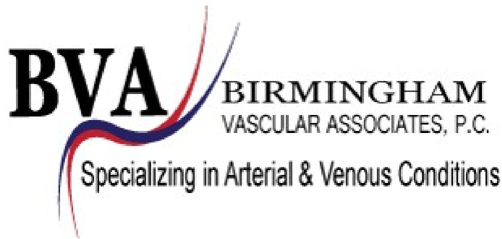

Robert W. Heidepriem, III, M.D., F.A.C.S.
Professional Office Building
2018 Brookwood Medical Center Drive, Suite 214
Birmingham, Alabama 35209
Phone: 205-423-2495
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www.birminghamvascularassociatespc.com

PATIENT REGISTRATION FORM

Referred by (Primary Care Physician, if required y Ins. Co.):____
Physician Address:____Physician Phone Number:______________________

PATIENT INFORMATION

Last Name:__________________First Name:__________________M.I._____Suffix(Jr., etc.)______Nickname:________________
Street Address:_____________________________________ SSN:_____________________DOB:____________Gender M__F__
Zip Code:__________City:__________________State:________Home Phone:________________Work Phone_______________
Cell Phone:_________________Email________________________________Marital Status: [__] S [__] M [__] D

Name of Employer:____________________________________Phone____

INSURANCE INFORMATION

Primary Insurance Company	Secondary Insurance Company
Company Name:_____________________________	Company Name:_____________________________
Group #:____________Pol#:___________Eff Date:_______	Group #:____________Pol#:___________Eff Date:_______
Relationship to Patient:__________________________	Relationship to Patient:__________________________
Name of Insured on card:_________________________	Name of Insured on card:_________________________
Address of Insured:______________________________	Address of Insured:______________________________
Zip Code:________City:__________________State:_____	Zip Code:________City:__________________State:_____
Insured's Social Security #:_______________________	Insured's Social Security #:_______________________
Home Phone:______________Wk Phone:______________	Home Phone:______________Wk Phone:______________
Insured's Date of Birth:__________________________	Insured's Date of Birth:__________________________
Insured's Employer:___________________Copay:$______	Insured's Employer:___________________Copay:$______

EMERGENCY NOTIFICATION INFORMATION

Contact Person (Other than spouse):_________________________Relationship:_________________Ph:______________

INJURY INFORMATION

Job Related?: [__] Yes [__] No | Date of Injury:_____Date Last Worked:______Employer(then):_______________________
Workman's Comp. Carrier:_________________________________Employer's Phone:___________________________
How did injury occur?:____
Employer's rep who authorized treatment:____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient:__________Responsible Party:__________________SSN:________________DL:______________
Street Address:____Zip:_________City:____________State:______________
Home Phone:________________Work Phone:______________Cell:________Name of Employer:___________________
Employer Street Address:_________________________________Zip:_________City:____________State:______________

Employer's Email Address:____

CONSENT FOR TREATMENT – RELEASE OF MEDICAL INFORMATION – FINANCIAL RESPONSIBLITY

I, the undersigned, consent to treatment necessary for the care of the above named patient. I hereby authorize the release of any or all medical records to the referring physicians, my insurance carriers, or those involved in payment of my account. I further acknowledge full financial responsibility for any service rendered by Birmingham Vascular Assoc. and understand that payment of charges incurred in the office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to Birmingham Vascular Assoc. in the event an account is not paid within 60 days, the undersigned agrees to pay all costs of collection including attorney fees and hereby waives all right of exemption under the Constitution of the State of Alabama.

Date:_______________ Signed:____