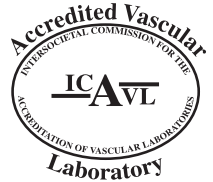






# THE VEIN & VASCULAR INSTITUTE OF TAMPA BAY

Thomas M. Kerr, M.D. • Marlene D. Valentin, M.D.  
2801 W. Waters Avenue • Tampa, FL 33614 • (813) 348-9088 • (813) 348-9310 Fax



## Patient Information Form

*Welcome to our office. Please complete this form and return it to our receptionist along with proof of Insurance/Insurance Card.*

Account # \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Personal Information

Name (please print): \_\_\_\_\_  
*Last First MI*

Address: \_\_\_\_\_  
*City State Zip*

Home Phone: (\_\_\_\_) \_\_\_\_\_ Sex: M F  Married  Single  Divorced  Widowed

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_

Spouse's SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

### Insurance Information

Primary Insurance: \_\_\_\_\_ Insurance Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Insurance Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

### Medical Information

Current Medications: \_\_\_\_\_

Allergies to Medication: \_\_\_\_\_

Has patient had treatment or X-rays? \_\_\_\_ Yes \_\_\_\_ No With Whom?: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

If injury, describe how, when and where patient was injured: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Local person to contact in case of emergency (Not living with you):

Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

### Release and Assignment

I hereby authorize **Thomas M. Kerr, M.D. / Marlene D. Valentin, M.D.** to release my medical records to the insurance companies covering the illness/injury for which I have been treated. Further, I authorize said insurance companies to issue payment directly to **Thomas M. Kerr, M.D. / Marlene D. Valentin, M.D.** for any claims submitted. I understand that I am personally responsible for any balances not paid by my insurance.

Signature of Patient/Guarantor: \_\_\_\_\_ Patient Name: \_\_\_\_\_