LONG ISLAND
VEIN CARE & SURGERY PLLC.

Chief Complaint / Reason for Visit:

_____

_____

Patients Name: _____ Age: _____ Sex: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Cell Phone: _____ Email: _____
How should we contact you with test results and insurance information? _____
May we leave a detailed message? _____
Primary Care Physician: _____ PCP Phone #: _____
How did you hear about us? : _____
Patient's Employer: _____ Work Phone: _____
Emergency Contact Name: _____ Phone #: _____

Primary Insurance Information
Primary Insurance Company: _____
Insurance ID #: _____ Group #: _____
Name of Insured: _____ DOB: _____
Relationship to Patient: _____
Insured Employer: _____ Work #: _____

Secondary Insurance Information
Secondary Insurance Company: _____
Insurance ID #: _____ Group #: _____
Name of Insured: _____ DOB: _____
Relationship to Patient: _____
Insured Employer: _____ Work #: _____

Insurance Authorization
I hereby authorize, Edwin H. Rosenwasser, MD, FACS, to furnish information to the insurance carriers concerning illness and treatment upon their request. I assign all the payments of medical services rendered for myself or dependents sent to the physician. I understand that I am responsible for any amount not covered by the insurance company such as a deductible, co-insurance or co-payment. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____