Ever Clinic

Date		PCP	
Referred by		Reason for appointment	

Basic Patient Information

Name		SS Number		DOB	
Address					
City		State		Zip Code	
Cell phone		Home Phone		Work Phone	
Email					

Medical Decision Maker	Name		Relationship	
Prefered Contact Method	☐ Phone Call ☐ Email ☐ Text Message			

Pharmacy

Name		Address	

Insurance Information

Insured's Name		DOB	
Relationship			
Primary Insurance Company			
ID Number		Group Number	
Secondary Insurance Company			
ID Number		Group Number	

I understand and acknowledge that I am responsible for informing Grand Vein Specialists, Ever Clinic of any changes to my demographics and/ or insurance policy before the time of my appointment. I understand that failing to do so can affect payment from my insurance company and can results in paying out of pocket for the services rendered in the facility.

_______________________________ _______________________

Patient Signature Date