Reno Vein Clinic

Robert F. Merchant, Jr., M.D | 9480 Double Diamond Pkwy, Ste, 100 Reno, NV 89521 775-329-3100 | **John W. Daake, M.D.**

PLEASE PRINT CLEARLY

PATIENT INFORMATION

Last Name:_______________________________ First Name:_________________ MI:____ Sex: ____ Marital Status: __________

Address: ____ Birth Date: ______/ ______ / ______ Age: _________

City: ____________________ State: ______ Zip: ____________ Social Security #: __________ - _____ - ___________

Occupation: __________________________ Employer: ______________________________

Phone Numbers: Home: _(_____)_______________ Cell: _(_____)_______________ Work: _(_____)_______________

Referred by: Dr. _____________ Family _____________ Friend _________________________

Newspaper ________ Radio ______________ Yellow Pages ___________________

TV _____________ Internet _____________ Magazine _____________________

In case of emergency Reno Vein Clinic should contact: _____________________________@ (phone)_____________________________

Relationship:________________________________

INSURANCE INFORMATION

Please bring all insurance cards with you to your appointment.

Primary Insurance Carrier: ________________________________

Insured's Name ____

Insured's Date of Birth: _____ / _____ / _________

Policy or Group Number _________________________________

Insured's Social Security # _________ - _____ - _________

Secondary Insurance Carrier: ___________________________

Insured's Name ____________________________________

Insured's Date of Birth: _____ / _____ / _________

Policy or Group Number _______________________________

Insured's Social Security # _________ - _____ - _________

I hereby authorize the treatment of the person or persons above, agree to pay all fees and charges for such treatment and further recognize that special arrangements for payment must be made prior to the actual delivery of service. I hereby assign, transfer and set over all of my right, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand and agree to accept full responsibility for total charges if my insurance company fails to pay. As a courtesy, The Reno Vein Clinic/Alta Surgery Center will bill my insurance company for charges related to services rendered.

Patient's Signature____ **Dated** __________________________

Photography Permission / Denial

I, the undersigned, do hereby give my permission for photographs to be taken at The Reno Vein Clinic. Privacy will be maintained at all times. The Reno Vein Clinic will not use these photos for publication without a signed release. I understand that my face or identifying features will not be incorporated into any reproduction that might be made available to my healthcare insurance carrier or any other person.

Patient's Signature ______________________________ **Witnessed by** _________________________ **Date** ____________

□ ***I do NOT want any photographs taken at all.*** ______________________________________

Patient's Signature

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