VeinCare Centers of Tennessee
647 Dunlop Lane, Ste 100, Clarksville, TN 37040
(931) 551-8991 phone (931) 551-4053 fax
www.TennesseeVeinCare.com

Patient Information Form

Please print and complete all fields, then sign and date.

Personal Information

Full Name: ____
Last *First* *Middle*

Address: ____
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Date of Birth: ______________ Social Security #: ______________ Gender: ☐ Female ☐ Male

Employer: ____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name: ____

Referring Physician: ______________________ Primary Care Physician: ______________________

Is this accident related? ☐ Yes ☐ No Date of Injury: ____________ Claim #: ____________

How did you hear about our practice? ☐ Physician ______________ ☐ Friend ______________

☐ Leaf Chronicle ☐ Television ☐ AT&T Yellow Pages ☐ YMCA Ad ☐ Clarksville Athletic Club Ad
☐ Radio ☐ Billboards ☐ TennesseeVeinCare.com ☐ VeinDirectory.com ☐ Facebook
☐ Clarksville VIP Magazine

Insurance Information

	1. Primary Insurance	2. Secondary Insurance
Company:		
Policy #:		
Group #:		
Effective:		
Relationship to patient	☐ Self ☐ Spouse/Partner ☐ Parent	☐ Self ☐ Spouse/Partner ☐ Parent

Complete section below ONLY if Spouse/Partner or Parent is checked above.

Name of Insured:		
Date of Birth:		
SS# of Insured:		
Employer:		

Signature of Patient or Guardian: ______________________________ **Date:** ______________

(Please complete other side)

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Patient Contact Information

Full Name: ____
Last *First* *Middle*

Please Circle:

Race: American Indian Alaskan Native Native Hawaiian/Pacific Islander
African American Caucasian Asian Decline to report/Unreported

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Decline to report/Unreported

Language: ______________________

Please indicate your preferred method of contact in which you would like us to contact you to confirm *appointments or provide information regarding your medical care.*
NOTE: As a courtesy, we will attempt to contact you to confirm your appointments.

☐ Home Phone # ______________________

☐ Work Phone # ______________________

☐ Cell Phone # ______________________

Is it ok to leave a message on your answering machine? ☐ Yes ☐ No

Is it ok to leave a message with a family member? ☐ Yes ☐ No

Name of family member: ______________________

Name of family member: ______________________

Emergency Contact Information

Full Name: ______________________ Relationship: ______________________

Home #: ______________________

Work #: ______________________

Cell #: ______________________

Do you give permission to release information to the Emergency Contact Provided?

☐ Yes ☐ No

Pharmacy Information

Pharmacy Name: ____

Pharmacy Phone #: ____

Pharmacy Address: ____

I give consent to VeinCare Centers of Tennessee to request a medication list from my insurance company or pharmacy.

Signature Date

Patient Portal:

Would you like to have access to the Patient Portal? You can see your information and alerts about appointments, along with other great features.

☐ Yes, please sign me up. My email address is ________________________________.

☐ No, I do not wish to participate because ____________________________________.