



Praveen K. Malhotra, M.D.

PATIENT INFORMATION:	EMERGENCY CONTACT:
Name: _____	Name: _____
Address: _____	Street: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____ Relationship: _____
Cell Phone: _____	PHYSICIANS:
Work Phone: _____	Referring Doctor: _____
Email: _____	Family Doctor: _____
Employer: _____	If not referred by a doctor, how did you hear about the Vein Care Center? _____
Date of Birth: _____ Age: _____ Sex: _____	
Marital Status: _____ S.S#: _____	
RESPONSIBLE PARTY:	INJURY/ACCIDENT INFORMATION
Name: _____	Is This Work Related: _____
Employer: _____	Has this been filed with workman's comp?: _____
Social Security #: _____	Date of Injury: _____
Date of Birth: _____ Relationship: _____	Information : _____
INSURANCE INFORMATION	
<i>Primary Insurance</i>	<i>Secondary Insurance</i>
Policy Holder: _____	Policy Holder: _____
Employer: _____	Employer: _____
Insurance Co. Name: _____	Insurance Co. Name: _____
Policy No.: _____	Policy No.: _____
Group No.: _____	Group No.: _____
S.S #: _____ Date of Birth: _____	S.S #: _____ Date of Birth: _____

Privacy policy and disclosure of information The Vein Care Center has the right to disclose protected health information for the purpose of treatment, payment or health care operations. I hereby authorize direct payment of medical benefits to the Vein Care Center for services rendered by them in person or under their supervision. I understand that by signing this form I am financially responsible for payment of any balances due. I hereby authorize treatment by the physician and staff. I authorize physicians and health care providers to treat me as they deem medically necessary for conditions they have diagnosed.

Patient Signature: _____

Date: _____