LAFAYETTE Regional Vein & Laser Center
A UNITY HEALTHCARE PARTNER

PATIENT INFORMATION

DATE: _____

NAME: _____ **ADDRESS:** _____

SOCIAL SECURITY #: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

DATE OF BIRTH: _____ **HOME PHONE:** _____

SEX: (circle one) FEMALE MALE **CELL PHONE:** _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

EMPLOYER: _____ **SPOUSE NAME:** _____

OCCUPATION: _____ **SOCIAL SECURTIY#:** _____

WORK PHONE: _____ **DATE OF BIRTH:** _____

EMAIL: _____ **EMPLOYER:** _____

MAY WE CONTACT YOU AT WORK: Y/N **OCCUPATION:** _____

REFERRAL SOURCE: (check one) FRIEND/FAMILY_____ PHYSICIAN_____ NEWSPAPER _____ YELLOW PAGES_____
RADIO STATION_____CHANNEL OTHER _____

EMERGENCY CONTACT: _____ **PHONE NUMBER:** _____
Relationship to patient: _____

PRIMARY CARE PHYSICIAN: _____
Address: _____ City: _____ Zip Code: _____
Specialty: _____ Telephone: _____ FAX: _____
May we contact: Y / N

OB/GYN PHYSICIAN: _____
Address: _____ City: _____ Zip Code: _____
Specialty: _____ Telephone: _____ FAX: _____
May we contact: Y / N

PODIATRIST: _____
Address: _____ City: _____ Zip Code: _____
Telephone: _____ FAX: _____
May we contact: Y / N

PREFERRED PHARMACY (NAME AND ADDRESS) _____ Phone: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

Telephone: _____ ID# _____ GROUP #_____

SECONDARY INSURANCE COMPANY: _____