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:** ______________________________

PLEASE CIRCLE YOUR SELECTION

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED **PREFERRED LANGUANGE**: ENGLISH SPANISH ____________

ETHNICITY: ____

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 _____ Name:________________ PHYSICIAN_____ Name:______________________
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:____

Telephone**:** ________________________________ ID#: __________________________ GROUP#: __________