



A Center Exclusively for the Treatment of Varicose and Spider Veins



Vanishing Veins

Lori L. Greenwald, MD, FACS
Medical Director

Date: _____

Patient Name: _____ Sex: M ___ F ___
(Please print) Last First M

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Do not give us your e-mail address unless we are allowed to use it as a method to contact you or to send you promotional information.

E-mail: _____

Date of Birth: _____ Marital Status: Single: ___ Married: ___ Divorced: ___

Occupation: _____ Employer: _____

Employer Address: _____ Phone #: _____

Emergency Contact: _____

Phone #: _____ Relationship: _____

Primary Care Physician: _____ Phone #: _____

How did you hear about Vanishing Veins? (Please check all that apply) Radio ___ Station? ___ TV ___ Website ___

Referred By: _____

INSURANCE INFORMATION

DOES YOUR INSURANCE REQUIRE A REFERRAL? (Please Check) Yes: ___ No: ___

Primary Carrier: _____ Secondary Carrier: _____

Identification Number: _____ Identification Number: _____

Name of Insured: _____ Name of Insured: _____

Employer: _____ Employer: _____

Group Name/ Number: _____ Group Name/Number: _____

SS Number of Insured: _____ SS Number of Insured: _____

Insured Date of Birth: _____ Insured Date of Birth: _____

Relationship to Insured: _____ Relationship to Insured: _____

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