spartz VEIN CLINIC

1835 W. County Rd C Suite 250
Roseville, MN 55113

1185 Town Centre Dr Suite 145
Eagan, MN 55123

P: 651-797-6880 F: 651-797-6881

info@spartzvein.com spartzvein.com

Date: _____ ***(office use) MRN:*** _____

Contact Information

Last Name: _____ First Name: _____ Mid Int: _____

Preferred Name: _____ DOB: _____ /_____/_____

What is your current gender identity? (Check all that apply)

Male____ Female____ Transgender Male/Transman/FTM____ Transgender Female/Transwoman/MTF____ Gender Queer____

other (specify)_____ Decline____

Preferred Pronoun: She/her/hers____ He/him/his____ They/them/theirs____ Other: Please specify_____

Relationship Status: Single _____ Married ____ Divorced _____ Widowed_____ Partnered_____ Other_____

Address: _____

City: _____ State: _____ Zip Code: _____

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

Which phone is primary: home☐ cell☐ work☐ Do we have permission to leave a detailed message on all phones/email? yes☐ no☐

Would you like text reminders? Yes____ No____ Email: _____

Employment status: FT ___ PT ___ Unemployed ____ Student ____ Self-employed _____ Retired: _____ Other_____

Occupation: _____

Race: American Indian/Alaska Native Hispanic/Latino Asian Black/African American Native Hawaiian/Pacific Islander White

Ethnicity: _____ 1st language: _____ 2nd language: _____

Emergency Contact Information

Name: _____ Phone: _____

Relationship to you: _____ May we speak with this person regarding your schedule or care?☐Y ☐N

Insurance Information

How will you be paying for your medical services? ☐ Insurance ☐ Self Pay ☐ Other _____

PRIMARY INSURANCE:

Insurance Name: _____ Subscriber: _____ DOB: _____

Group#: _____ Member Id: _____

SECONDARY INSURANCE:

Insurance Name: _____ Subscriber: _____ DOB: _____

Group#: _____ Member Id: _____

How did you hear about Spartz Vein Clinic? _____

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I have contacted my insurance company to verify my network and benefits. Yes_____ No_____

I understand that I am responsible for all charges incurred for my care and I am responsible to pay for non-covered services.

I also authorize the release of pertinent medical information necessary to process my insurance claim and further my care.

Signature: _____ Date: _____