Varicose Vein Laser Center &Med Spa

2457 W. Beverly Blvd Montebello, Ca 90640
Zelda E. Billingy, M.D
(323)722-0312

Patient Information:

Thank you for choosing our practice for your health care needs. Please complete this form in pen. If you have any questions or concerns, do not hesitate to ask for assistance, we will be happy to help you.

Name:_____DOB:___/___/_____SS#:_____
First Middle Last

Address:_____City:_____Zip:_____

Gender: F M Marital Status: M S Spouse:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

E-mail:_____How do you prefer we contact you:_____

Emergency Contact:_____Phone:_____Relationship:_____

Employer:_____Address:_____

Referred to our office by:_____Primary Doctor:_____

Insurance Verification:

Insurance Company:_____Phone:_____

Policy #:_____Coverage: HMO PPO MEDICARE OTHER:_____

Deductible:_____Met: Y N Copay:_____

AUTHORIZATION TO PAY PHYSICIAN

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN AND I AM FINANCIALLY RESPONSIBLE FOR NON COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION NECESSARY TO PROCESS CLAIMS.

I certify that the above information is complete and accurate.

Signature of Patient:_____Date____/____/_____

PLEASE NOTE: Some of our procedures are **NOT COVERED** by insurance and **PAYMENT** is due at the time of your scheduled appointment.**Thank you!**