ORANGE COUNTY VASCULAR SPECIALISTS, INC.

Stephen F. Lindsay, M.D. ● John W. Puckett, M.D. ● David Nabi, M.D.
520 Superior Ave. Suite 370 ● Newport Beach, CA 92663
(949) 574-7176 ● FAX (949) 574-7180 ● www.vasculardocs.com

An important event is scheduled. Your regular doctor is concerned that you have a problem with your vascular system and has requested that you have an evaluation. **We will try to see you on time but occasionally we are detained by emergencies that will delay the visit or cause it to be rescheduled. We apologize in advance if either of these takes place**.

Name: _____Birth Date: _____ Age: _____

Sex: M F Social Security #: XXX-XX-_____ Drivers License #: _____

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

Home #: _____ Cell #: _____ Work #: _____

E-Mail Address: _____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name: _____ Primary Physician: _____

Spouse's Phone: _____ Referred By: _____

Employer: _____ Pharmacy: _____ Phone: _____

Occupation: _____ Pharmacy: (Street, City) _____

Preferred means of communication (circle one) Home Phone Cell Phone Email USPS Mail

Do we have your permission to leave messages regarding lab results and/or appointments on your answering device, or with another person who answers the phone? □ Yes □ No

Designated Emergency contact person (not living with you):
Name: _____ Phone: (_____) _____ Relationship: _____

Who is your Power of Attorney for Healthcare?
Name: _____ Phone: (_____)_____ Relationship: _____

Financial Information

Person Responsible for Account: _____

Relationship: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Insurance Assignment and Consent to Release Information

Primary Insurance Company: _____ Subscriber's Name: _____

Insured's ID#: _____ Group #: _____

Secondary Insurance Company: _____ Subscriber's Name: _____

Insured's ID#: _____ Group #: _____

I request that payment of authorized Medicare Benefits and/or Insurance Benefits be made on my behalf to Dr. Stephen F. Lindsay, Dr. John W. Puckett, and/or Dr. David Nabi for any services furnished to me by the physicians and I irrevocably assign all payment for medical service rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, and/or any other insurance carrier, any information needed to determine these benefits or the benefits payable for related services. In addition, I authorize the above named physicians to release any information concerning my medical condition, including the diagnosis and records of any treatment or examination, to Medicare or any other insurance carrier or physician. A photostat copy of this assignment shall be considered as valid as the original.

Insured's Signature _____ Patient's Signature _____ Date _____