

Date : \_\_\_\_\_

**SAVANNAH VASCULAR INSTITUTE  
PATIENT INFORMATION**

To All Patients: Payment is expected at the time of service. Please indicate your payment preference:

\_\_\_ Cash \_\_\_ Check \_\_\_ Credit Card

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**Please Print Clearly:**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Marital Status \_\_\_ Married \_\_\_ Single Sex \_\_\_ Male \_\_\_ Female Race \_\_\_\_\_ SSN \_\_\_\_\_  
Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Address \_\_\_\_\_  
Referred by \_\_\_ Self \_\_\_ Family/Friend (Name) \_\_\_\_\_ Dr (Name) \_\_\_\_\_

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**Spouse/Responsible Party Information:**

Spouse Name: \_\_\_\_\_ Responsible Party \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ SSN \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

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**If patient is a dependent/minor, please complete the following:**

Legal Guardian/Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ SSN \_\_\_\_\_

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**PRIMARY** Insurance Company \_\_\_\_\_ Insurance ID# \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Group# \_\_\_\_\_ Insured's Name \_\_\_\_\_  
Insured Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Sex \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Employer Name \_\_\_\_\_ Co-Pay Amount \_\_\_\_\_  
Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_

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**SECONDARY** Insurance Company \_\_\_\_\_ Insurance ID# \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Group# \_\_\_\_\_ Insured's Name \_\_\_\_\_  
Insured Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Sex \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Employer Name \_\_\_\_\_ Co-Pay Amount \_\_\_\_\_  
Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_

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**WORKER'S COMPENSATION** Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Group# \_\_\_\_\_ Insured's Name \_\_\_\_\_  
Insured Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Sex \_\_\_\_\_  
Employer Name \_\_\_\_\_ Co-Pay Amount \_\_\_\_\_  
Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_

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Person who does not live with you to contact in emergency \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_