

**VASCULAR SURGERY
ASSOCIATES P.A.**



*Vein Institute
of the Midwest*

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vascularsurgeryassoc.net

Patient Information

Name _____ Date of birth _____ Age ____ Sex: []Male []Female
Address _____

Are you presently in a nursing facility? []Yes []No If yes, what is the name? _____

Best contact number: _____ []home []cell []work []nursing home
Alternate contact number: _____ []home []cell []work []nursing home
email: _____

Your SSN: _____ Marital status: []single []married []divorced []widowed
Race: []Asian []Native Hawaiian []Black []White []Hispanic []Other Ethnicity: []Hispanic/Latin []non-Hispanic

Emergency contact _____ Relationship _____ Phone number _____

It is the policy of *Vascular Surgery Associates, P.A.* NOT to release confidential information regarding your medical care to any unauthorized person(s). Please designate below the individuals you would like to specify as "authorized" to receive your medical information.

AUTHORIZED PERSON(S):

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Referred by _____ Primary Physician _____
Phone number _____ Phone number _____
Fax number _____ Fax number _____

Pharmacy of choice _____ Phone number _____

Hospital of choice: 1. _____ 2. _____

How did you hear about us? []Primary Physician []Friend []Advertisement []Insurance []Other: _____

Primary insurance _____ ID Number _____ Group Number _____

Is this an HMO? _____ Is a referral required? []Yes []No

Name of insured _____ Date of birth: _____ Relationship: _____

Secondary insurance _____ ID Number _____ Group Number _____

Name of insured _____ Date of birth: _____ Relationship: _____

Are you on dialysis? []Yes []No

Which dialysis center? _____

Phone number: _____

Dialysis days: []M/W/F []TThSat

Nephrologist: _____

Are you being seen by home health? []Yes []No

Agency: _____