

**THE VAIN CLINIC, LLC
PAMELA ROBETS, M.D.**

PATIENT'S NAME _____
(LAST) (FIRST) (MIDDLE)
SS# _____ DATE OF BIRTH ____/____/____

GUARANTOR (IF PATIENT IS CHILD) _____

FL ADDRESS: _____ APT # _____

CITY _____ ST _____ ZIP _____ PH # _____

SEASONAL ADDRESS: _____ APT # _____

MARITAL STATUS _____ DRIVER'S LICENSE # _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ PH # _____

EMERGENCY CONTACT _____ PH # _____

CONTACT'S ADDRESS: _____

CITY _____ ST _____ ZIP _____

INSURANCE INFORMATION

PRIMARY

NAME OF INS CO. _____ PH# _____

ADDRESS _____

IF GROUP INS, PLEASE SPECIFY WHICH EMPLOYER CARRIES IT _____

NAME OF INSURED _____ DOB: _____ SS# _____
POLICY # _____

GROUP# _____ MEDICARE # _____ AUTH # _____

SECONDARY

NAME OF INS CO. _____ PH# _____

ADDRESS _____

IF GROUP INS, PLEASE SPECIFY WHICH EMPLOYER CARRIES IT _____

NAME OF INSURED _____ DOB: _____ SS# _____
POLICY # _____ GROUP # _____

ASSIGNMENT OF BENEFITS

I authorize the release of any payment and medical information necessary to process this claim and related claims. I request Payment of benefits to Pamela Roberts, M.D., The Vain Clinic, LLC., who accepts assignment of benefits.

(Patient or Authorized Person's Signature) DATE ____/____/____

REFERRING PHYSICIAN INFORMATION

NAME _____ UPIN # _____ PH # _____

ADDRESS _____