

Texas Vein and Cosmetic Specialists

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PATIENT INFORMATION: PLEASE PRINT

LAST NAME FIRST NAME M.I. DATE OF BIRTH

S M W D SEP.

SOCIAL SECURITY # DRIVER'S LICENSE # MALE/FEMALE

ADDRESS CITY ST ZIP

EMAIL ADDRESS PHONE (primary) C W H

HOME PHONE CELL PHONE WORK PHONE

EMPLOYER

NAME CITY ST ZIP

REFERRING PHYSICIAN

NAME ADDRESS PHONE

PRIMARY CARE PHYSICIAN

NAME ADDRESS PHONE

PHARMACY PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE PHONE

POLICYHOLDER DOB RELATIONSHIP

POLICY NUMBER GROUP NUMBER

POLICY HOLDER EMPLOYER

NAME ADDRESS PHONE

SECONDARY INSURANCE PHONE

POLICYHOLDER DOB RELATIONSHIP

POLICY NUMBER GROUP NUMBER

POLICY HOLDER EMPLOYER

NAME ADDRESS PHONE

I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO MICHAEL F. BARDWIL, M.D., FOR SERVICES RENDERED BY HIM IN PERSON OR UNDER HIS DIRECT SUPERVISION. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE FOR ANY REASON. _____ (INITIALS) I HEREBY AUTHORIZE MICHAEL F. BARDWIL, M.D., AND/ OR HIS STAFF PERMISSION TO RELEASE OR OBTAIN INFORMATION ABOUT ME IN REGARDS TO MY MEDICAL CARE OR FOR THE PROCESSNG OF MY INSURANCE CLAIMS. _____ (INITIALS)

PATIENT OR GUARDIAN'S SIGNATURE

DATE