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S Scott Tapper MD FACS
Robyn Hicks RN BSN CE
Stacey Brown, ARNP

Patient Name _____ Today's Date _____

DOB ____/____/____ Age _____ Social Security# _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home # _____ Cell# _____ Work# _____

E-mail Address _____

Patient's Employer _____

Address _____ Phone# _____

IN CASE OF EMERGENCY NOTIFY _____

RELATIONSHIP _____ PHONE NUMBER _____

How were you referred to our office?

- Physician Dr.
Family/Friend
Newspaper
other
Yellow Pages
Insurance Directory
Mailer
Postcard

Cosmetic Services are not covered by health insurance. Payment will be collected when services are rendered. Thank you for your cooperation.

Health Insurance Coverage

Please present your insurance card & photo ID at check in

- Medicare
Florida Blue Cross & Blue Shield
UHC
Cigna
Other

Subscriber's Name (if different than Patient): _____ DOB ____/____/____

I HEREBY ASSIGN PAYMENT DIRECTLY TO SYMMETRY LASER VEIN CENTER FOR THE AMOUNT DUE FOR MEDICAL/ SURGICAL EXPENSES INCURRED AND PAYABLE UNDER TERMS OF MY BASIC INSURANCE AS WELL AS MAJOR MEDICAL BENEFITS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS ASSIGNMENT. PHOTOCOPIES OF THIS FORM WILL BE VALID. I AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR CLINIC TO PROVIDE FULL DETAILS OF MY MEDICAL HISTORY AND TREATMENT TO SYMMETRY LASER VEIN CENTER

Patient Signature: _____ Date: _____