MID MICHIGAN VASCULAR SURGERY

RONALD A. BAYS M. D. RYAN J. KIM M. D.
4701 TOWNE CENTRE SUITE 202
SAGINAW, MI 48604
PHONE (989) 790-2600 FAX (989) 790-3311

Welcome! We are delighted to have you as our patient. Please help us obtain the yearly insurance signatures and information that is required by law yearly. Thank you.

DATE COMPLETED: _____

PATIENT NAME: _____ SEX: M F SS#: _____

D.O.B.: _____ AGE: _____ MARITAL STATUS: M S D W

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PHONE#: _____ (HOME) _____ (WORK) _____ (CELL)

EMAIL: _____

IF MARRIED: SPOUSE NAME: _____ DOB: _____

SPOUSE SS#: _____ PHONE #: _____

- IF YOU ARE UNDER YOUR SPOUSE'S INSURANCE WE WILL NEED ALL OF THEIR INFORMANTION FILLED OUT ABOVE AND CARRIER SUBSCRIBER #

CARRIER SUBCRIBER #:_____

EMPLOYMENT STATUS: FULL TIME PART TIME DISABLED RETIRED

EMPLOYER: _____ RETIREMENT DATE: _____

REFERRING DOCTOR: _____ PHONE#: _____

ADDRESS: _____ CITY: _____ ZIP:_____

FAMILY DOCTOR: _____ PHONE #: _____

ADDRESS: _____ CITY: _____ ZIP:_____

CARDIOLOGIST: _____ PHONE#: _____

ADDRESS: _____ CITY: _____ ZIP:_____

INSURANCE: 1. _____ 2. _____ 3. _____

IS THIS A WORKMAN COMPENSATION CLAIM OR AUTO CLAIM? Y N

(IF YES) CLAIM#: _____ DATE OF INJURY: _____

PLEASE SIGN THE BACK OF THIS FORM