

EAST TENNESSEE VASCULAR CENTER, PLLC
SHAHIN ASSADNIA, M.D.
1125 West 1st North Street, Suite B
MORRISTOWN, TN 37814
PHONE (423) 317-6560 FAX (423) 317-6570

NAME: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____
(STREET NUMBER) (CITY) (STATE) (ZIP)

SOCIAL SECURITY #: _____ MARITAL STATUS: Divorced Married Single Widowed

HOME PHONE: _____ DATE OF BIRTH: _____ AGE: _____ SEX: M F

WORK PHONE: _____ OCCUPATION: _____

EMPLOYER: _____
(NAME OF EMPLOYER) (ADDRESS)

SPOUSE NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ EMPLOYER: _____

FAMILY DOCTOR: _____ PHONE: _____

WHO REFERRED YOU TO DR. ASSADNIA ? : _____

HAVE YOU SEEN DR. ASSADNIA IN THE HOSPITAL? Y / N WHERE? _____ WHEN? _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP TO PATIENT: _____ or _____

ARE YOU ALLERGIC TO ANYTHING? () YES () NO () DON'T KNOW
IF YES: WHAT? _____

INSURANCE INFORMATION:

DO YOU HAVE HEALTH INSURANCE? () YES () NO

PRIMARY INSURANCE COMPANY

NAME: _____

NAME OF POLICYHOLDER: _____ POLICYHOLDER DOB: _____

POLICY #: _____ GROUP #: _____

SECONDARY INSURANCE COMPANY

NAME: _____

NAME OF POLICYHOLDER: _____ POLICYHOLDER DOB: _____

POLICY #: _____ GROUP #: _____

DO YOU HAVE A COPAY ? () YES () NO AMOUNT OF COPAY? _____

PLEASE SHOW INSURANCE CARDS TO RECEPTIONIST

SIGNATURE: _____ DATE: _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to Dr. Assadnia and I am financially responsible for non-covered services. I also authorize the physician to release any information required to receive payment.