BOULDER VEINCENTER
goodbye vein, goodbye pain

Anderson Medical Center
4743 Arapahoe Avenue, Suite 102
Boulder, CO 80303

www.boulderveins.com
Phone 303.449.8346 Fax 303.440.7298

Today's Date: _____

PATIENTS FULL NAME (please print):_____ Date of Birth:_____

GUARANTOR INFORMATION: Person who is responsible for payment.

Name: _____ Employer Name: _____

Address:_____ Employer Address: _____

City:_____ State:_____ Zip:_____ City:_____ State: _____ Zip:_____

Home Phone:_____ Employer Phone: _____

Date of Birth:_____ Relationship to Patient: _____

Please complete the section below if you are over 18 and wish to allow a friend, spouse, parent, or other family member to discuss medical and/or billing information with our office.

Authorization to Discuss Medical and Billing Information

I, _____ , hereby authorize Alpine Surgical to discuss my medical and billing information with the following listed persons:

First and Last name of authorized person:	Relationship: (i.e.: mother, son, spouse, friend)
1:_____	1:_____
2:_____	2:_____
3:_____	3:_____
4:_____	4:_____

Patient Signature: _____ **Date**: _____