

Vascular Associates of San Diego

Vincent J. Guzzetta, M.D.

Scott E. Musicant, M.D.

Thomas T. Terramani, M.D.

PATIENT INFORMATION
(Please Print)

Date _____

Patient's Name _____ Phone _____
Last First M

Address _____ Other Phone _____
Number & Street City State Zip

Birthdate _____ Age _____ Social Security Number _____

Spouse or Guardian _____ Marital Status _____

Patient's Employer _____ Phone _____

Occupation _____

Spouse's Employer _____ Phone _____

.....
Patient's Insurance _____ ID# _____

Address _____ Phone _____

Subscriber's Name _____

Secondary Insurance _____ ID# _____

.....
Family Physician _____ Referred by _____

Emergency Contact _____ Phone _____

Address _____ Relationship _____

.....
I hereby authorize and request _____ Insurance Company to assign directly to your physician all payments due for services rendered by said doctor.

I understand that I am financially responsible for all charges not covered by insurance.

Signature _____ Date _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

Vincent J. Guzzetta, M.D., F.A.C.S.
Scott E. Musicant, M.D., F.A.C.S.
Thomas T. Terramani, M.D., F.A.C.S.
8860 Center Dr., Suite 450
La Mesa, CA 91942
(619) 460-6200

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it

Name _____ Birthdate _____

Signature _____ Date _____

I understand that my personal health information may be shared with other physicians and/or hospitals as is necessary for medical care.

My personal health information, either verbally or written, may also be released to the following:

Name _____ Phone # _____

Relationship _____

Name _____ Phone # _____

Relationship _____

Name _____ Phone # _____

Relationship _____

Patient Signature _____ Date _____