

**VEIN CLINIC OF SOUTH TEXAS-----ROBERT H. JOHNSTON, JR., M.D., PA**  
**VICTORIA: 6412-B N Navarro\*\*\*361-570-8346      CORPUS CHRISTI: 5920 Saratoga, Suite 620\*\*\*361-991-8346**

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell \_\_\_\_\_ Fax \_\_\_\_\_ E-Mail \_\_\_\_\_

Employer \_\_\_\_\_ Emp. Phone \_\_\_\_\_

Spouse \_\_\_\_\_ Spouse's SSN \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Emp. Phone \_\_\_\_\_

Person to notify in case of emergency \_\_\_\_\_ Relationship \_\_\_\_\_  
(Different than spouse or parent)

Address \_\_\_\_\_ Phone \_\_\_\_\_

**REFERRAL SOURCE** (How did you hear about us?) \_\_\_\_\_

**REFERRING DOCTOR** \_\_\_\_\_

**PRIMARY INSURANCE** \_\_\_\_\_ Certificate & Group # \_\_\_\_\_  
(must present ID card for copying)

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

**(if other than patient)**

Employer of Insured \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

**SECONDARY INSURANCE** \_\_\_\_\_ Certificate & Group # \_\_\_\_\_  
(must present ID card for copying)

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

**(if other than patient)**

Employer of Insured \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

**Medicare #** \_\_\_\_\_ **Medicaid #** \_\_\_\_\_

**FAMILY OR PREVIOUS DOCTOR:** \_\_\_\_\_

**FINANCIAL RESPONSIBILITY - ASSIGNMENT OF INSURANCE BENEFITS**

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and or dependents. I hereby authorize payment directly to **Vein Clinic of South Texas – Victoria, 6412 N Navarro Ste B – and Corpus Christi, 5920 Saratoga Blvd Ste 620 / Robert H. Johnston, Jr., M.D.** all benefits, if any, otherwise payable to me for his/her services as described on the attached forms, or may be applied to any outstanding balance on my account. Furthermore, I understand I am financially responsible for all charges incurred.

\_\_\_\_\_  
(Authorized Signature of Subscriber)

\_\_\_\_\_  
(Date)