WISCONSIN RADIOLOGY SPECIALISTS, S.C.
VARICOSE VEIN CENTER

PATIENT REGISTRATION FORM

❑ Dr. James Beres ❑ Dr. John Tomashek

Today's Date ________/_________/__________

PATIENT INFORMATION (Please Print)

Legal Name____ DOB ________/________/__________
Last First MI

Mailing Address____
Street City State Zip

E-Mail ____

❑ Female ❑ Male ❑ Married ❑ Single Primary language: ____________________________

Primary phone number: (   ) ________________________ MAY WE LEAVE A MESSAGE? ❑YES ❑NO

Alternate number you would like to list? ❑YES ❑NO (   ) _______________ MAY WE LEAVE A MESSAGE? ❑YES ❑NO

May we leave a message with a family member/health care taker/place of employment ❑YES ❑NO

(Optional) Emergency contact name (other than self): _________________________ Relationship to you: ________________

Their phone number: (   ) __________________ MAY WE LEAVE A MESSAGE ❑YES ❑NO

Employment Information

Employer ____________________________ Occupation _________________________ Work Phone (   ) ____________

Insurance Information

Primary Insurance Company: _________________________ Secondary Insurance Company: ________________________

Provider Employee ID #_____________________________ Provider Employee ID#: _____________________________

AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize Wisconsin Radiology Specialists, S.C. to release any information concerning my care to my insurance company. I also authorize the release of information to and from my primary or referring physician that they may deem pertinent to my care.

ASSIGNMENT OF BENEFITS. I hereby authorize, request and assign payment directly to Wisconsin Radiology Specialists, S.C. by all insurance carriers and Social Security administrators with whom I have coverage or for who benefits are, or may become, payable to me, including settlements of judgments arising from the incident for which I am receiving treatment. I agree to pay all charges not paid by my insurance plan.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE. I acknowledge that I have received a copy of Wisconsin Radiology Specialists, S.C. Privacy Practices. I understand that the Notice of Privacy provides an explanation of the ways in which my health information may be used or disclosed by Wisconsin Radiology Specialists, S.C. and my rights with respect to my health information.

The undersigned has read and understands the above.

Date __________________________ (Signature of Patient or Patient's Legal Representative – if patient is unable to sign)

(Relation to Patient)

FOR OFFICE USE ONLY

❑ Patient was unable or unwilling to complete this form or portions of this form. Explain: ______________________________________