WISCONSIN RADIOLOGY SPECIALISTS, S.C.
VEIN CENTER

PATIENT REGISTRATION FORM

❑ Dr. John Tomashek

Today's Date _____/_____/_____

PATIENT INFORMATION (Please Print)

Legal Name_____ DOB _____/_____/_____
Last First MI

Mailing Address_____
Street City State Zip

E-Mail _____ Primary language: _____

Sex: ❑ Male ❑ Female Marital Status: ❑ S ❑ M ❑ D ❑ W

Primary phone: ( ) _____ ❑Cell ❑Home MAY WE LEAVE A MESSAGE? ❑YES ❑NO

Secondary phone: ( ) _____ ❑Cell ❑Home MAY WE LEAVE A MESSAGE? ❑YES ❑NO

Employment Information

Employment Status: ❑ Employed ❑ Full-Time Student ❑ Part-Time Student ❑ Self Employed ❑ Retired ❑ Unemployed

Employer: _____ Occupation _____

Work Phone ( ) _____ EXT: _____

Insurance Information

Primary Insurance Company: _____ Secondary Insurance Company: _____

Subscriber Name: _____ ❑ M ❑ F Subscriber Name: _____ ❑ M ❑ F

Subscriber DOB: _____/_____/_____ Subscriber DOB: _____/_____/_____

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)

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