



Wisconsin Vein Center & MediSpa

PATIENT INFORMATION (Please print & use pen only)

How did you hear about us? _____

PATIENT NAME: _____ PHONE: _____

BIRTHDATE: _____ AGE: _____ CELL PHONE #: _____

M ___ F ___ MARITAL STATUS: **S / M / W / D** SOCIAL SECURITY #: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

EMAIL ADDRESS: _____

PRIMARY DR/CITY: _____ REFERRING DR/CITY: _____

NAME OF EMPLOYER: _____ PHONE: _____

INSURANCE INFORMATION (we will need a copy of your insurance cards)

PRIMARY INS: _____ SUBSCRIBER: _____ GRP NAME: _____

CARD HOLDER SSN: _____ CARD HOLDER DOB: _____

SECONDARY INS: _____ CARD HOLDER: _____ GRP NAME: _____

CARD HOLDER SSN: _____ CARD HOLDER DOB: _____

To Whom May We Give Medical Information Regarding Your Care:

Only Myself: ___ Spouse: ___ Other: _____ May we leave a message on an answering machine: **Y / N**

May we contact you at: Home: **Y / N** Work: **Y / N** Cell: **Y / N** Email: **Y / N**

Would you like to receive information about upcoming promotions, specials, or seminars? **Y / N**

CONSENT FOR TREATMENT AND BILLING OF SERVICES

I AUTHORIZE AND CONSENT TO THE PERFORMANCE OF EXAMINATIONS, DIAGNOSTIC PROCEDURES, AND TREATMENTS WHICH MY ATTENDING PHYSICIAN AND I AGREE ARE NECESSARY. THIS CONSENT SHALL REMAIN IN EFFECT UNTIL I CHOOSE TO REVOKE IT IN WRITING. I AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION AND/OR TREATMENT TO SPECIFIED PHYSICIANS AND/OR MY INSURANCE COMPANY. I PERMIT PAYMENT OF SERVICES RENDERED TO BE DISPERSED DIRECTLY TO DEBORAH L. MANJONEY, MD. I RECOGNIZE AND ACCEPT FINANCIAL RESPONSIBILITY FOR ALL BALANCES REMAINING AFTER PROCESSING OF SUCH BENEFITS. ALL PATIENT PORTIONS TO INCLUDE: APPLICABLE DEDUCTIBLES, COPAYMENTS, COINSURANCE, AND NON-COVERED SERVICES WILL BE DUE AT THE TIME OF SERVICE. A PHOTOSTATIC COPY OF THIS FORM IS AS VALID AS THE ORIGINAL.

SIGNED: _____

DATE: _____

MEDICARE/MEDIGAP AUTORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO DEBORAH L. MANJONEY, MD FOR ANY SERVICES FURNISHED ME BY THAT PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS AUTHORIZATION IS IN EFFECT UNTIL I CHOOSE TO REVOKE IT IN WRITING.

SIGNED: _____

DATE: _____