WIDMEYER
VEIN & WELLNESS CENTER

NEW PATIENT REGISTRATION

Name_____

Date of Birth_____ Social Security Number_____

Street
Address_____

City_____ State _____ Zip_____

Home Phone_____ Cell Phone_____

Work Phone _____ Email_____

Primary Care Physician _____ Phone _____

Referring Doctor (if any) _____ Phone _____

Insurance Company Name_____ Member # _____

HIPPA Consent: I authorize Widmeyer Vein & Wellness to furnish my insurance company with any information required to collect payment for my medical services. I am aware that I am personally responsible for all charges not paid to my insurance company. I will be responsible for all outside collections and attorney fees and court costs. You may be contacted by any telephone number associated with your account.

Signature _____ Date _____

Email back to: info@widmeyervein.com