Patient Registration

Last Name:
SSN:
Address 1:
Zip Code:
Home:
Work:
Email:
Date Of Birth:
Gender:
Marital Status:

PATIENT INFORMATION

Address 2:
City:
State:
Cell:
First Name:
MI:

RESPONSIBLE PARTY INFORMATION
MEDICAL INFORMATION

Last Name:
First Name:
MI:
Patient's Relationship to Responsible Party:
Responsible Party Address:
City:
State:
Zip Code:
Responsible Party Home#:
Responsible Party Work#:
Referring Physician:
Primary Insurance Name:
Plan Name:
Address:
City:
State:
Zip:
Policy#:
Group#:
DOB:
For Medicare Patients: Are You or Your Spouse Working?:
YES
NO
If Yes, Whom:
Sex:
Policy Holder Name:

PRIMARY INSURANCE INFORMATION

Policy Holder Address:
Zip:
State:
City:
-
Policy Holder's Work#:
Policy Holder's Home#:
Patient's Relationship to Policy Holder:
Employer:

Secondary Insurance:
Plan Name:
Address:
City:
State:
Zip:
Policy#:
Group#:
DOB:
Sex:

Policy Holder Name:

SECONDARY INSURANCE INFORMATION

Policy Holder Address:
City:
State:

Zip:
Policy Holder's Home#:
Policy Holder's Work#:
Patient's Relationship to Policy Holder:
Employer:
Is this visit related to an auto accident?
Date of Injury
Y N
Is this visit related to an injury sustained while at work?
Y N

To Our Female Patients:

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members.

By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

_____ _____/_____/_____
Signature of Patient or Personal Representative Date

Date of Last Menstrual Period: _____

AUTHORIZATION AND AGREEMENT

I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use and disclose any of my personal health information for treatment and payment. If I am UNINSURED, I understand I am fully responsible for all charges.

_____ _____/_____/_____
Signature of Patient or Personal Representative Date