

Patient Registration



Patient Information

Name: _____ Gender _____
Date of Birth _____
Address (please include City, State, Zip) _____
SS# XXX-XX-_____
Home/cell Phone _____

If person other than the patient is responsible for the bill please indicate below

Guarantor Name _____

Is your visit due to an **auto** accident or **workplace** injury? Yes / No

If yes, please supply accident information below.

Work Injury _____ Auto Injury _____ Date of Injury _____

Insurance Name _____ Claim Number _____

Patient Employer Information

Employer Name _____ Work Phone Number _____

Primary Insurance Information

Insurance Name _____

Policy Number _____ Group Number _____

Is this insurance issued by the patient's employer Yes / No

If no, Please provide the policy holders information below

Relationship to Patient _____ Insured Name _____

Insured Date of Birth _____

Secondary Insurance Information

Insurance Name _____

Policy Number _____ Group Number _____

Is this insurance issued by the patient's employer Yes / No

If no, Please provide the policy holders information below

Relationship to Patient _____ Insured Name _____

Insured Date of Birth _____

Patient Acknowledgment

I authorize the release of any medical information necessary to process the bill for this exam to my insurance company, and I request payment of benefits to the Center for Medical Imaging. I acknowledge that I am financially responsible for payment whether or not it is covered by insurance.

Signature of Patient or Patient representative _____ Date _____