

CMI Patient Registration Form

INSTRUCTIONS

Thank you for choosing The Center for Medical Imaging. Please return a completed patient registration form at your earliest convenience, so we can schedule your appointment right away.

INSTRUCTIONS

1. COMPLETE THE FORM

Either Fill it out online and print it.
Or Print it and hand-write your responses.

2. RETURN THE FORM

Either Mail or deliver it to the address above.
Or Fax it to (503) 216-8410.

Any questions? Please call us at (503) 216-8400.

CMI Patient Registration Form

Patient name _____ Social security # _____

Date of birth _____ Home phone (____) _____

Sex M F Marital status Married Single Divorced Widowed

Address _____
(Street) (City/State/ZIP)

Employer name _____ Work or alternate phone (____) _____

Employer address _____
(Street) (City/State/ZIP)

Referring physician _____ Co-payment amount \$ _____

Person Responsible for Bill (Complete only if different from patient)

Guarantor name _____ Guarantor social security # _____

Relation to patient Self Spouse Partner Parent Legal guardian

Date of birth _____ Sex M F Phone (____) _____

Address _____
(Street) (City/State/ZIP)

Emergency contact (if different from guarantor) _____

Relation of emergency contact to patient _____ Work or alternate phone (____) _____

Primary Insurance Information (Policyholder's information)

If Medicare, do you have Part B coverage? Yes No

Plan name _____ ID # _____ Group # _____

Address _____
(Street) (City/State/ZIP)

Policyholder _____ Social security # _____

Date of birth _____ Sex M F

Secondary Insurance Information (Policyholder's Information)

Plan name _____ ID # _____ Group # _____

Address _____
(Street) (City/State)

Policyholder _____ Social security # _____

Date of birth _____ Sex M F

Is your visit due to a job related injury or automobile accident? (If yes, please explain the circumstances to our receptionist) Yes No

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 representative _____ Date ____/____/____

For Official CMI Use Only

MRN: _____

Date received: (__/__/__) Received by: _____

Reviewed by: _____ Title: _____ Date: (__/__/__)

Request accepted:

Request mailed or given to patient on: (Date) (__/__/__)

Request denied on: (Date) (__/__/__)

Denied by: _____ Title: _____

Reason denied: _____

Transaction
completed by: _____ Title: _____ Date: (__/__/__)