Please Print

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ SEX ____ DOB_____ AGE____

PREVIOUS NAME IF APPLICABLE _____ SOCIAL SECURITY NUMBER _____

ADDRESS _____ PHONE (HOME)_____

CITY, STATE _____ (CELL) _____

ZIPCODE _____ (WORK) _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ CITY, STATE, ZIP CODE _____

EMERGENCY CONTACT _____ PHONE _____

REFERRED BY _____ PHONE _____

EMAIL ADDRESS _____

PARENT, GUARDIAN, SPOUSE

LAST NAME _____ FIRST NAME _____ SEX ____ DOB_____ AGE____

PREVIOUS NAME IF APPLICABLE _____ SOCIAL SECURITY NUMBER _____

ADDRESS _____ PHONE (HOME)_____

CITY, STATE _____ (CELL) _____

ZIPCODE _____ (WORK) _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ CITY, STATE, ZIP CODE _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

NAME OF INSURED _____ DOB _____ SOCIAL SECURITY NUMBER _____

SECONDARY INSURANCE COMPANY _____

NAME OF INSURED _____ DOB _____ SOCIAL SECURITY NUMBER _____

I understand as the Consenting Party, I am responsible for payment of this account

PURPOSE OF YOUR VISIT _____

RELEASE AND ASSIGNMENT

This patient registration form must be completed in its entirety & the Release & Assignment Authorization signed by the Responsible/Consenting Party prior to treatment. Medical Imaging Consultants considers this information a condition of treatment.

1. I hereby authorize the Providers of Medical Imaging Consultants to perform such procedures as may be deemed necessary in the diagnosis & treatment of the patient.
2. I hereby authorize release of any medical information regarding this visit to my insurance and/or primary care physician & also assign to the provider all payments from my insurance company.
3. I understand that I am financially responsible for all charges whether or not paid by insurance.
4. I understand that not all providers at Medical Imaging Consultants may be a participating provider with my insurance. I understand that I am responsible for charges not covered by my insurance.
5. I understand and agree to the above conditions.

AUTHORIZATION SIGNATURE _____ **DATE** _____

THIS AGREEMENT WILL REMAIN ON FILE FOR APPROXIMATELY ONE YEAR & WILL BE CONSIDERED A CONDITION OF ALL TREATMENTS UNTIL A NEW FORM IS COMPLETED.