PATIENT REGISTRATION FORM

Patient Name ____

DOB ____ SS# ________________________________

Mailing Address ____

City, State, Zip ____

Street Address ____

Home Phone ___________________ Work Phone __________________ Cell Phone _______________

Emergency Contact _______________________________ Phone # _____________________________

❑ Male ❑ Female

Are you or could you be pregnant? ❑ Yes ❑ No

Responsible Party Name __________________________ Relationship to Patient ___________________

Responsible Party SS# ____________________________

Referring Doctor ____________________________ Primary Doctor ______________________________

❑ Single ❑ Married ❑ Widowed ❑ Other ❑ Employed ❑ Self Employed ❑ Retired ❑ Student

Employer Name ____

Is injury related to ❑ job or ❑ auto accident or ❑ neither. Date of injury _____________ State _______

Billing Insurance ❑ No ❑ Yes (please complete the following)

Primary Insurance _______________________ Policy # ____________________ Group # ______________

Policy Holder Name ______________________ Relationship ________________ DOB ________________

Policy Holder's Employer ____

Secondary Insurance _____________________ Policy # ____________________ Group # _____________

Policy Holder Name ______________________ Relationship ________________ DOB ________________

PATIENT REGISTRATION FORM (continued)

Policy Holder's Employer ____

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of this physician/clinic for the medical benefits, if any, otherwise payable to me for services. I understand I am financially responsible for the charges not covered by my insurance company. I acknowledge that I have received a copy of PRIVATE PRACTICES FOR PRESCOTT MEDICAL IMAGING.

Signed (Patient or Guardian) ____ Date ____