IMAGE NORTH

Advanced Radiology Specialists

PATIENT REGISTRATION

Welcome to our imaging center!
We strive to make your visit with us pleasant and comfortable. Due to the increased requirements of insurance companies, and to help us better serve your needs; please take a few minutes to complete the following information

PATIENT INFORMATION

Who may we thank for referring you? ____________________

Patient Name: ____________________
(First) (Middle Initial) (Last)

Sex: M F Birth date: __________ Age: _____ Marital Status: S M D W Soc. Sec.#.: __________

Mailing Address: ____________________

City: __________ State: __________ Zip Code: __________

Home Phone: __________ Work Phone: __________ Cell Phone: __________

E-mail Address: ____________________
May we have your permission to e-mail you regarding upcoming imaging center information and events? YES / NO

Employer: __________ Address: __________ Ph: __________

PCP : __________ Address: __________ Ph: __________
(Primary Care Physician)

Emergency Contact: __________ Relationship: __________

Emergency Contact Phone No.: __________

INSURED PARTY INFORMATION

What is the name of your insurance company? ____________________
Please provide us with a copy of your insurance card.
*If your insurance is an HMO, please provide a copy of your referral from your PCP upon completion of the form.
*Is today's exam related to a **MOTOR VEHICLE ACCIDENT** or **WORKER'S COMP CLAIM?** YES / NO
If yes, please inform receptionist **IMMEDIATELY** for additional information.

Parent/Guardian/Insured's Name: ____________________
(First) (Middle Initial) (Last)

Sex: M F Birth date: __________ Age: _____ Soc. Sec. #: __________

Mailing Address: ____________________

City: __________ State: __________ Zip Code: __________

Home Phone: __________ Work Phone: __________ Cell Phone: __________

RESPONSIBLE PARTY INFORMATION (Please complete if patient is a minor.)

Parent/Guardian Name: ____________________
(First) (Middle Initial) (Last)

Mailing Address: ____________________

City: __________ State: __________ Zip Code: __________

Sex: M F Birth date: __________ Age:_____ Soc. Sec. #: __________