



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/dinic 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 _____