

Registration Form

Patient Information

Exam Date: 11/30/2010 2:45:00 PM

Patient Last Name _____ Patient First Name _____ Gender Unknown

MRN _____ Social Security Number _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____ Marital Status _____

Occupation _____ Employer _____

Employer's Address _____ City _____ State _____ Zip _____

Referring Physician

Referring Physician _____ Phone _____

Address _____

How did you hear about us? Doctor Family Friend Other (Specify)

Responsible Party /Emergency Contact

Name Self _____ Relationship _____

Birthdate _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Employer _____

Employer's Address _____ City _____ State _____ Zip _____

Occupation _____ Business Phone _____

Relationship to Patient _____

Who should we notify in case of an emergency? _____

Name _____ Phone _____

Address _____ Relationship _____

Insurance

On The Job? Motor Vehicle Accident? Date of Injury _____ Authorization _____

PRIMARY INSURANCE _____ Business Phone _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy Number _____

Policy Holder D.O.B. _____ Group Number _____

SECONDARY INSURANCE _____ Business Phone _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy Number _____

Policy Holder D.O.B. _____ Group Number _____

Release of Information and Payment Authorization

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Next Generation Radiology. I authorize the release of any medical information necessary for treatment by my current or future physician or health care provider. I authorize Next Generation Radiology to release to my insurance company any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance company denies this claim, I will be held financially responsible for all charges.

I acknowledge that I have received a copy of Next Generation Radiology's Privacy Notice. Initials: _____

Patient or Guardian Name Signature Date