DIAGNOSTIC IMAGING CENTERS, P.A.

Patient Registration Form

PATIENT INFORMATION

MR#: _____ Admit Date: _____

Last Name: _____ First: _____ Middle: _____

Date of Birth: _____ Sex: _____ SSN #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Daytime Phone: _____ Email Address: _____

Requesting Physician: _____

_____ ***By placing my initials in the space provided, I verify that I have reviewed the information above and it is correct.***

GUARANTOR INFORMATION

Relationship to Patient: _____ Name: _____

Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE INFORMATION

Plan: _____ Policy #: _____

Group #: _____ Insured's Relationship to Patient: _____

Name of Insured: _____ SSN of Insured: _____ DOB of Insured: _____
(If other than Patient)

SECONDARY INSURANCE INFORMATION

Plan: _____ Policy #: _____

Group #: _____ Insured's Relationship to Patient: _____

Name of Insured: _____ SSN of Insured: _____ DOB of Insured: _____
(If other than Patient)

ACKNOWLEDGEMENT / WAIVER OF LIABILITY

Please initial by each statement below:

1. _____ I hereby authorize and request payment to Diagnostic Imaging Centers, P.A. for any Medical Benefits due under the terms of my insurance policy for services rendered. I further authorize the release of all necessary information including reports, images and outcomes as requested by my Insurance Carrier(s).

2. _____ I have been informed by Diagnostic Imaging Centers, P.A. that my procedure may not be a covered service. I understand that charges for all services provided but not covered by my insurance will be my financial responsibility.

3. _____ I authorize the release of all or any portion of my medical record to any health care practitioner or facility designated by me.

_____ _____

Patient or Parent (If Minor) Signature ***Date***