DIAGNOSTIC IMAGING CENTERS, P.A.

Patient Registration Form

PATIENT INFORMATION

MR#: _____ ADMIT DATE: _____

Last Name: _____ First: _____ Middle: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

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

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____

Exam:_____ Diagnosis: _____

Requesting Physician:_____

PATIENT'S EMPLOYER INFORMATION

Employer: _____

GUARANTOR INFORMATION

Relationship to Patient:_____

Name: _____

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

INSURANCE INFORMATION

Plan: _____

Policy #: _____ Group #: _____

Name of Insured (if other than patient):_____

SSN of Insured (if other than patient):_____ DOB of Insured: _____

Insured's Relationship to Patient:_____

ACKNOWLEDGEMENT

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).

I understand that charges for all services provided but not covered by my insurance will be my responsibility.

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