PATIENT REGISTRATION

Last Name: ________________ First Name: ________________ Middle Initial: _____

SSN: ______________________ DOB: ______________________

Address: ____________________________________ Apt #:__________________________

City: _______________________________________ State/Zip: _______________________

Home Phone: ___________________________ Work Phone: __________________________

Cell Phone: ______________________________ Email: _________________________

Referring Physician: ______________________ Phone: _________________________

Emergency Contact: ____________________ Phone: _________________________

Employment Status:

- o FULL-TIME
- o PART-TIME
- o RETIRED
- o UNEMPLOYED

Marital Status:

- o MARRIED
- o SINGLE
- o DIVORCED
- o WIDOWED

Insurance: _____________________________ ID/Policy Number:____________________

Are you the primary for the insurance? [ ]YES [ ]NO ______________________________

Supplemental/ Co-Insurance:_____________________________________

If Film or CD's are requested, we require a 24 hour notice. Advanced Imaging is not responsible for personal items. Personal items are to be locked in locker or kept with you at all times. Your referring physician will contact you with exam results after reviewing reports. The staff of Advanced Imaging is not authorized to give verbal results.

Patient Signature: ______________________________________ Date: __________________