

PATIENT REGISTRATION

Today's Date _____ Date of onset/accident/symptoms: _____
Reason for visit: _____
Referring Doctor: _____ Phone: _____

PATIENT INFORMATION:

Patient Last Name: _____ First: _____ MI: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Phone: Home _____ Work _____
Sex: M / F Date of Birth (M/D/Yr): _____ Age: _____
Weight: _____
Marital status: (S) (M) (D) (W) Social Security #: _____
Employer Name: _____

IF PATIENT IS A MINOR:

Emergency Contact: Name: _____ Phone: _____ Relationship: _____
Parent/Guardian Address, if different: _____ Phone: _____
City: _____ State: _____ Zip: _____
WORK COMP INJURY? _____ **AUTO ACCIDENT INJURY?** _____

Do you have an attorney regarding this injury? Yes _____ No _____
If yes: Name: _____

Address: _____

PATIENT INSURANCE INFORMATION:

Name of Insurance Company: _____ Subscriber Name: _____
Relationship to Pt.: _____ Subscriber's Social Security #: _____
Subscriber DOB: _____ Employers Name (Group): _____
ID #: _____ Group #: _____
Secondary Insurance Company: _____ Subscriber's Name: _____
Relationship to Pt.: _____

Insurance Billing: I hereby certify that the information I have reported above with regard to my insurance coverage is correct and further authorize Greater Northeast Radiology Associates, P.C. to furnish my insurance company with all information which my insurance company may request concerning my present illness or injury. I hereby assign to Greater Northeast Radiology Associates, P.C. all money to which I am entitled for all expenses related to the service reported above. Direct Billing: If my insurance company denies coverage of the expenses related to the service date reported above, I will promptly pay such expenses. In addition, I will pay any costs incurred in collecting the amount of such expenses from me.

Patient Signature

Date

Office Staff Witness