

REGISTRATION FORM

(Please Print)

Today's Date:		PCP:	
PATIENT INFORMATION			
Patient's Legal Last Name:		First:	Middle:
		<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	
		Marital Status (circle one)	
		Single/ Mar/ Div/ Sep/ Widow(er)	
Language:	Interpreter Needed? Y/N	Social Security Number:	Birth Date: / /
Ethnicity:	Race:		Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:		Home Phone number: ()	Cell Phone: ()
P.O. Box:	City:	State:	Zip Code:
Employment Status:	Employer Address:		Employer Phone Number: ()
Referred to clinic or hospital by (please check one box): <input type="checkbox"/> Doctor _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow pages <input type="checkbox"/> Other _____			
Other family members seen here:			

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist)			
Person responsible for the bill:		Birth Date: / /	Address (if different):
		Home Phone Number: ()	
Employment Status:	Employer and Address:		Employer Phone Number: ()
Is this patient covered by insurance? <input type="checkbox"/> Y <input type="checkbox"/> N			
Name of Primary Insurance:		Group Number:	Policy Number:
Subscriber's Name:		Subscriber's Social Security Number:	Birth Date: / /
		Co-payment: \$	
Patients relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Name of Secondary Insurance (if applicable):		Group Number:	Policy Number:
Subscriber's Name:		Subscriber's Social Security Number:	Birth Date: / /
		Co-payment: \$	
Patients relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
IN CASE OF EMERGENCY			
Name of local friend or relative (not living in the same address):		Relationship to patient:	Home Phone Number: ()
			Work Phone Number: ()

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Imaging Associates of Providence or insurance company to release any information required to process my claims.

Patient/Guardian signature:

Date: