IMAGING ASSOCIATES
Expert Radiology. Exceptional Care.

REGISTRATION FORM

(Please Print)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's Legal Last Name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status (circle one) Single/ Mar/ Div/ Sep/ Widow(er)

Language:	Interpreter Needed? Y/N	Social Security Number:	Birth Date: / /	Age:	Sex: ☐ M ☐ F
Ethnicity:	Race:				

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): ☐ Doctor _____ ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow pages ☐ 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? ☐ Y ☐ 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: ☐ Self ☐ Spouse ☐ Child ☐ 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: ☐ Self ☐ Spouse ☐ Child ☐ 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: