

## PATIENT REGISTRATION FORM

Patient Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F (Circle one) Married/Single/Divorced/Widow

Address: \_\_\_\_\_  
(Street) (City/State/Zip)

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Would you be interested in having communications sent to you via your e-mail address? (examples: appointment reminders, administrative updates and health bulletins) Yes No

Employer Name: \_\_\_\_\_ Employer Phone Number: (\_\_\_\_) \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(Street) (City/State/Zip)

Primary Care Physician: \_\_\_\_\_ Copay Amount \$ \_\_\_\_\_  
(Name)

How did you hear about our Practice? \_\_\_\_\_

### Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone Number: (\_\_\_\_) \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(Street) (City/Street)

### Who to call for an emergency:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship: \_\_\_\_\_

### FIRST INSURANCE INFORMATION

Plan Name: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

Address: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

### SECOND INSURANCE INFORMATION

Plan Name: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

Address: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y \_\_\_\_ N \_\_\_\_  
IF YES, PLEASE COMPLETE BACK OF FORM AND NOTIFY THE RECEPTIONIST

It is our policy to bill your insurance carrier as a courtesy to you. Quotes given to patient at time of service are an estimation given by your insurance company. The patient/guarantor is ultimately responsible for all charges. If High Field Open MRI should have to pursue collections the patient/guarantor will be responsible for all charges and legal fees pertaining to collection of outstanding debt.

I authorize the release of any information including diagnosis and records of treatment/examination as necessary to secure payment.

I authorize and request my insurance company to pay directly to High Field Open.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_