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: ____________________