PATIENT REGISTRATION

Last Name _____ First Name_____ Middle Initial _____

Mailing Address _____ City/State/Zip _____

Telephone (____)_____ Social Security # _____ Date of Birth _____

Cell Phone (_____)_____

Gender: ___Male ___ Female Marital Status: ___Single ___Married ___Divorced ___Widowed

INFORMATION FOR SELF	Spouse-Name:
Employer	Spouse-Date of Birth:
Employer Address	Spouse-Employer:
City/State/Zip	Employer Address:
Telephone ( )	City/State/Zip:
	Telephone ( )

Have you ever had services at this Center prior to today? _____ Yes _____No If yes, date _____

GUARANTOR (Person signing for financial responsibility – if different from PATIENT)

Last Name _____ First Name_____ Middle Initial _____

Mailing Address _____ City/State/Zip _____

Telephone (_____)_____ Social Security # _____ Date of Birth _____

Relationship to patient _____

Employer/Address/City/State/Zip _____

EMERGENCY CONTACT

Emergency Contact Name _____ Telephone (_____)_____

Relationship to Patient _____

REFERRING PHYSICIAN

Name of Physician/Specialty: _____ Telephone (___)_____

Address/City/State/Zip _____

Primary Care Physician (PCP)/Specialty: _____ Telephone (___)_____

Address/City/State/Zip _____

PATIENT RELEASE AGREEMENT

1.) I request that this facility render medical services to me.
2.) I understand that I am fully responsible for payment of all charges resulting from such authorized medical treatment and that such charges are due and payable at the time of service, unless I have made other arrangements regarding a fee payment schedule.
3.) I authorize this facility to release information regarding my MRI and/or my medical condition and treatment to my insurance company, physician, attorney and/or other health care professionals involved in my medical care. I hereby release this facility from all legal responsibility or liability that may arise from the act that I have authorized.
4.) I hereby authorize this facility to obtain any medical records and/or reports from my physician, hospital or other facility. This information is to be used for comparison, as well as my diagnosis.
5.) I authorize payment of benefits from my insurance coverage directly to this facility.

Signature: _____ Date: _____