



REGISTRATION INFORMATION

PATIENT INFORMATION (PLEASE USE FULL LEGAL NAME)

Last: _____ First: _____ MI: _____ Sex: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Other Phone: _____ DOB: _____
Social Security#: _____ Marital Status: Married Single Divorced Widowed
Employer: _____ Job Title: _____
Employer Address: _____ Work Phone: _____
Emergency Contact Name: _____
Emergency Contact Phone number: _____

RESPONSIBLE PARTY INFORMATION

Last: _____ First: _____ Relationship to Patient: _____
Address: _____ Social Security #: _____
DOB: _____ Employer: _____
Employer Address: _____ Phone Number: _____

INSURANCE INFORMATION

On the job injury: _____ Motor Vehicle Accident: _____

Primary Insurance

Insurance Company: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Policy Holder: _____ Policy #: _____ Group Number: _____
Adjuster: _____

Secondary Insurance

Insurance Company: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Policy Holder: _____ Policy #: _____ Group Number: _____

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Health Images. I authorize the release of any medical information necessary for treatment by my current or future physician or healthcare provider. I authorize Health Images to release to my insurance company any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance company denies this claim I will be held financially responsible for all charges. I acknowledge that I have received a copy of Health Images' Privacy Notice.

Initials _____

Signed: _____ Date: _____