REGISTRATION INFORMATION

PH | 337-593-9500
FX | 337 593 0909

PATIENT INFORMATION

PATIENT NAME Last ____________________ First ________________ MI ____ ○Male ○Female

Address ____

City__________________________________ State ____________________ Zip ________________

Date of Birth ____/____/_______ Social Security # ________________________

Home Phone ___________________ Cell______________________

Employer ____ Job Title _____________________

Work Phone ____________________ Ext ______Emergency Contact ____________________________

Phone ___________________________

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POLICY HOLDER

Name ___________________________ Address ____

City ____ State ___________________ Zip ___________

Home Phone ____________________ Date of Birth ____/____/_______ Social Security _______________

Relationship to Patient ________________ Employer ____

Job Title ________________________ Work Phone ____________________ Ext. ______

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INSURANCE INFORMATION

On the Job Injury? ○YES ○NO Date of Injury ____/____/______ **Initial:**__________

Motor Vehicle Accident? ○YES ○NO Date of Injury ____/____/______ **Initial:**__________

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize the release of information to process this claim and assign benefits payable for services directly to Envision Imaging. I authorize the release of any medical information necessary for the treatment by my current or future physician or health care provider. I authorize Envision Imaging 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 denies this claim, I will be held financially responsible for all charges. I acknowledge that I have received a copy of Envision Imaging's Privacy Notice.

Initials:____

Printed Name ______________________________________ Date ____/____/______

Signature ____