**TRUE MEDICAL IMAGING**

# PATIENT REGISTRATION FORM

Today’s Date \_ Chart Number:

Referring Dr.: Dr. Phone# \_ Dr. Fax #\_

# PATIENT INFORMATION

Patient: Last Name: First: \_ Middle: \_\_ Maiden Name: \_ \_Marital Status: Single Married Divorce Separated Widow

Is this your legal name? Yes No If not, what is your legal name? **(Former name)**:\_

Birth Date: Age: S.S. #: \_Sex: Male **/** Female Address (No P.O. Box): City State\_ Zip code

Email Address:\_

Home # \_ Work # Cell #

Occupation: Employer:

Father’s Name \_\_ Mother’s Name\_ (Minor Child Only) (Minor Child Only)

S.S. #: - -\_ Birth Date: S.S. #: - - \_ Birth Date:

# INSURANCE INFORMATION

**(Please give your most current insurance card and valid ID to the receptionist)**

Name of Insurance: Person Insured Name: \_

Insured’s DOB \_ Relationship\_ \_

S.S. #\_ Policy#\_ Group#\_

Was this due to an accident? Date of Injury: \_Type of Injury: \_MVA \_Slip/Fall

Other: \_

# IN CASE OF EMERGENCY

Name of friend or relative **(living at the same address)** \_ \_

Relationship to Patient Home phone#

Name of friend or relative **(not living at the same address)**

Relationship to Patient Home phone#\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to True Medical Imaging. I understand that I am financially responsible for any balance. I also, authorize

True Medical Imaging, LLC or insurance company to release any information required to process my claims.

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Patient/Guardian signature Date

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