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: _____ Insured's DOB_____
Person Insured Name: _____ 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.

_____ _____

Patient/Guardian signature Date