



## REGISTRATION INFORMATION

### PATIENT INFORMATION

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: \_\_\_\_\_