MRI Center Patient Registration Form Date: _____ LOC: _____

Patient's Name (Last, First, MI):_____ SS#_____ Weight: _____
(Required by machine)

Date of Birth: _____ Age: ____ Sex: M F Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address: _____ City _____State: _____ ZIP _____

Is Patient a minor: ☐ NO ☐ YES Your Relationship to Minor: ☐ Parent ☐ Legal Guardian ☐ Other: _____

Patient's Primary Contact Number: _____ ☐ Cell ☐ Home Alt Number: _____

Emergency Contact: _____ Emergency Contact Number: _____

Emergency Contact Relationship:_____ Emergency Contact Number: _____

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EMPLOYER INFORMATION

IF PATIENT IS A MINOR, PLEASE ENTER RESPONSIBLE PARTY EMPLOYER

Patient Employment Status: ☐ FT ☐ PT ☐ Retired ☐ Not Employed ☐ Child (Enter Responsible Party Employer)

Employer:_____ Employer Phone Number: _____

Employer Address: _____ City _____State: _____ ZIP _____

Is this appointment due to a work or auto related accident/injury: ☐ NO ☐ YES Injury Date: _____

Workman's Comp Contact Name: _____ Claim #: _____

Auto Insurance: _____ Claim #: _____

Auto Insurance Address: _____

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INSURANCE INFORMATION

IF PATIENT IS A MINOR, PLEASE ENTER RESPONSIBLE PARTY INFORMATION

PRIMARY Cardholder/Guarantor:_____ DOB:_____

Phone #: _____ SS#_____

Address: _____ City _____ State: _____ ZIP: _____

Employer Name: _____ Phone _____ Fax _____

Address: _____ Contact Number: _____

City _____ State: _____ ZIP: _____

SECONDARY Cardholder/Guarantor: _____ DOB _____ SS# _____

Address: _____ City _____ State: _____ ZIP: _____

Employer Name: _____ Phone _____ Fax _____

Address: _____ Contact Number: _____

City_____ State: _____ ZIP: _____

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MEDICAL RECORDS RELEASE

Designee will be required to show proof of ID (i.e. Driver's License)

Other than your Physician(s), who has authorization to obtain a copy of your medical records on your behalf?

1. _____ 2. _____