PATIENT REGISTRATION FORM

Today's date:		Referring Physician:	

PATIENT INFORMATION

Patient's name:	Email address:

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Birth date:	Age:	Sex:

Street address:

City, State, Zip Code:	Social Security	Home Phone	Cell Phone

Marital Status:	Employer:	Employer phone #

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone #

Is this person a patient here? Yes ☐ No ☐

Occupation:	Employer:	Employer address:	Employer phone #

Name of primary insurance	

Subscriber's name:	Subscriber's S.S. #	Birth date:	Group #	Insurance ID #	Co-payment:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #	Insurance ID #

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

OPTIONAL:

Race:	Ethnicity:	Language:	Smoking Status:

IF WORK RELATED PLEASE INCLUDE THE FOLLOWING:

Date of Injury:	Claim Number:
Claims Examiner Name:	Phone Number:

How did Injury Occur:

IN CASE OF EMERGENCY

Name of local friend or relative (not at same address):	Relationship to patient:	Home phone #	Work phone #

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Silicon Valley MRI & CT, their contracted physicians, or my insurance company to release any information required to process my claims.

Patient/Guardian signature ______________________ Date ______________