-Southern Diagnostic Imaging-

REGISTRATION SHEET

Date: _____/_____/_____

Chart #: _____

PATIENT INFORMATION S.S. # _____/_____/_____ Age:_____

Name: _____ Sex: M F
(Last) (First) (M.I.) (Circle)

Address: _____ Date of Birth _____/_____/_____
(Street / Apt #)

_____
(City) (State) (Zip)

_____ _____ _____ _____ _____
Home Phone Other Phone Marital Status Driver's License Number State

Patient's Employer: _____
(Name) (Address and/or Phone Number)

Responsible Party: _____ _____
(if different than patient) (Name) (Relation) (Phone Number)

HEALTH INSURANCE INFORMATION: **YES, YOU MUST FILL THIS AREA OUT.**

Even though copies of cards are made, you need to fill out the following completely

Is your visit today related to an injury or accident? Yes / No
If yes, please provide the injury or accident date _____ / _____ / _____ **(MUST BE COMPLETE)**

- **Primary Insurance Name:** _____ Policy #: _____
  Holder's Complete Name: _____ Their Date of Birth: ____ / ____ / ____
  Holder's Social Security #:_____ / _____ / _____
  Holder's Employer: _____ Work #: _____

- **Secondary Insurance Name:** _____ Policy #: _____
  Holder's Complete Name: _____ Their Date of Birth: ____ / ____ / ____
  Holder's Social Security #:_____ / _____ / _____
  Holder's Employer: _____ Work #: _____

IS YOUR VISIT TODAY TO BE FILED AS WORKMAN'S COMP? **Yes / No**
If yes, be sure to list accident date above.

METHOD OF PAYMENT (IF REQUIRED): **Cash Check Visa Mastercard Discover**

AUTHORIZATION AND PAYMENT AGREEMENT

- I hereby agree to be responsible for the payment of all charges on the date incurred regardless of the status of medical or liability insurance claims, whether I sign as an agent, representative of, or as a patient receiving medical care, that in consideration of services rendered to the patient, I hear by obligate myself to pay the account in accordance with the regular rates and terms of present clinic policy. **Furthermore, I agree to pay all additional collection agency fees, attorney fees, and court costs that may be incurred or caused by not paying this account in full and/or on time.**
- Upon receipt of a properly executed request for release of medical information, I hereby authorize Southern Diagnostic Imaging to release information acquired in the course of my examination or treatment to the insured's Insurance Company, Medicare, Medicaid or Designee.
- This form has been fully explained to me and I certify that I understand its contents.

Signature of Patient or Responsible Party: _____ Date: _____/_____/_____

PLEASE PROVIDE THE RECEPTIONIST WITH YOUR INSURANCE CARD(S)