PATIENT REGISTRATION FORM
(PLEASE PRINT CLEARLY)

Patient's Name: ______________________________ **SS #:** ____________
First Name MI Last Name

Date of Birth: ____________ ☐Male ☐ Female ☐Single ☐Married ☐Widowed ☐ Divorced ☐ Separated

Street Address: ______________________________

City/State/Zip Code: ____________________ **Home Phone w/Area Code:** ____________

Cell Phone w/Area Code: ____________________ **Fax w/Area Code**: ____________

Patient's Employer: ____________________ **Work Phone w/Area Code:** ____________

Responsible Party: ____________________ **Relationship:** ☐Self ☐Spouse ☐Parent ☐Other:________

If patient is a Minor, are parents: ☐Married ☐Divorced Custodial Parent: ____________

Custodial Parent's Home Phone w/Area Code: ____________ **Work Phone w/Area Code:** ____________

Custodial Parent's SS #: ____________________ **Date of Birth:** ____________

In case of emergency, contact (not living with you): ______________________________

Phone Number w/Area Code: ____________ **Relationship to Patient:** ____________

Is this work-related? ☐Yes ☐No **If yes, date of injury?** ____________ **Claim #:** ____________

How did this injury happen? ______________________________

____

Referring Physician's Name & Phone Number: ______________________________

<u>PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION</u>

Insurance Company # 1: ____________________ **Phone Number:** ____________

<u>Primary Insured's Name</u>: ____________________ **<u>Date of Birth</u>:** ____________

Policy #: ____________ **Group #:** ____________ **Relationship:** ____________

Insurance Company # 2: ____________________ **Phone Number:** ____________

<u>Primary Insured's Name</u>: ____________________ **<u>Date of Birth</u>:** ____________

Policy #: ____________ **Group #:** ____________ **Relationship:** ____________

LIEN INFORMATION (separate lien agreement will need to be signed)

Attorney's Name: ____________________ **Phone #:** ____________

I authorize ProHealth Imaging Medical Group, Inc. to treat me and use my personal health information for healthcare operations.

______________________________ ____________

Patient's Signature (OR Parent if patient is a Minor) Date