

New Patient Registration

PATIENT INFORMATION (Please Provide a copy of a Valid ID) Please Print					
Patient Last Name:		First Name:		MI:	
Sex: M F	Date of Birth:		Social Security #:		
Street Address:			Home Phone:		
City:		State:	Zip Code:		
Marital Status: (circle one) Single Married Widowed Divorced Legally Separated					
Ordering Physician:					
Employer:					
Employment Address:			Employer Phone:		
Guardian/Spouse's Name:		Date of Birth:	Social Security #:		
Employer:			Employer Phone:		
Emergency Contact (Other than Spouse) Name:					
Address:			Phone:		
Is visit related to Accident or Injury? If yes, Date of Accident or Injury?					
Insurance Information: Primary Insurance Company:					
Policy ID:		Group #:			
Name of Insured:		Date of Birth:	Relation to Patient:		
Secondary Insurance:					

INSURANCE POLICY & PAYMENT We will file claims on your behalf to insurance companies. Medicare assignment is accepted on all patients for covered services. For all other cases, in order to provide cost-effective care, payment is requested at the time of service. In addition to cash, payment may be made using MasterCard, Visa, American Express or Discover/Novus.

Do you have a Living Will or Advanced Directives? Yes No Please provide a copy or advise staff

I hereby authorize Cascade Radiology to utilize my personal health information to diagnose, treat and obtain payment for services rendered.

I authorize payment directly to Cascade Radiology of any insurance policy benefits payable to me, and I hereby assign all such policy benefits. I understand I am financially responsible for all charges not covered by insurance, as well as all copayments required by insurance.

Patient Signature/Or Parent if Minor

Date