NorthStar RADIOLOGY

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Date

*Last Name | *First Name | M.I. | Social Security # | *Date of Birth | [x] Female [ ] Male

*Street address | APT # | *City | *State | *Zip | Country (US)

*Phone Number | Email | Marital Status | Spouse's First Name

*Employment Status | Employer | Work Phone | EXT

PRIMARY INSURANCE INFORMATION

*Does the patient have insurance? [ ] Yes [ ] No

*Patient relation to insured

*If the insurance carrier's information is the same as the above patient information, write 'same as above.'

*Insurance Company | *Insured Last Name | *Insured First Name | M.I. | *Date of Birth

*Group Number | *Street address | APT # | *City | State (AK) | Zip

*Policy Number | Country (US) | *Phone Number | *Employer | Work Phone | EXT

SECONDARY INSURANCE INFORMATION

*Does the patient have secondary insurance? [ ] Yes [ ] No

*Patient relation to insured

*If the insurance carrier's information is the same as the above patient information, write 'same as above.'

*Secondary Insurance | *Insured Last Name | *Insured First Name | M.I. | *Date of Birth

*Group Number | *Street address | APT # | *City | State (WA) | Zip

*Policy Number | Country (US) | *Phone Number | Employer | Work Phone | EXT

ASSIGNMENT OF INSURANCE BENEFITS *to be filled out and signed at check in with the receptionist on the date of your exam.*

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and my dependents, and that I will be bound by this signature as though the undersign had personally signed the particular claim.

I, _____ (Patient Name) hereby authorize _____ (Primary insurance company)

to pay **North Star Radiology** directly all benefits, if any, otherwise payable to me for their services as described on the attached forms. I understand I remain financially responsible for all charges incurred and any charges not paid by my insurance company will be my responsibility. I further acknowledge that any insurance benefits, when received by and paid to **North Star Radiology** will be credited to my account, in accordance with the above assignmen

Print Form | Reset Form

_____ Patient Signature | _____ Date

EC

Fairbanks Medical Imaging DBA North Star Radiology 2310 Peger Rd Suite 102 Fairbanks, AK 99709 Phone: 907.459.6555 Fax: 907.459.6566