PATIENT REGISTRATION

NorthStar RADIOLOGY

PATIENT INFORMATION

Last Name: _____ **First Name**: _____ **Middle Initial(s)**: _____
Billing Address (Street / P.O. Box): _____
City: _____ **State**: _____ **Zip Code**: _____
Date of Birth: _____ / _____ / _____ **Gender**: ☐ Male ☐ Female **Social Security Number**: _____ - _____ - _____
Phone Number: (_____) _____ - _____ **Email**: _____
Emergency Contact Name: _____ **Emergency Phone Number**: (_____) _____ - _____
Reason for Visit (If Applicable): ☐ Motor Vehicle Accident ☐ Work-Related Injury

GUARENTOR INFORMATION – PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR (UNDER 18 YEARS OLD)

Last Name: _____ **First Name**: _____ **Middle Initial(s)**: _____
Billing Address (Street / P.O. Box): _____
City: _____ **State**: _____ **Zip Code**: _____
Date of Birth: _____ / _____ / _____ **Social Security Number**: _____ - _____ - _____

PRIMARY INSURANCE INFORMATION

Do you have insurance?: ☐ Yes ☐ No **Insurance Company**: _____
Insurance Group Number: _____ **Insurance Policy Number**: _____
Insurance Address (Street / P.O. Box): _____
City: _____ **State**: _____ **Zip Code**: _____
Insured Last Name: _____ **Insured First Name**: _____ **Middle Initial(s)**: _____
Relation to Insurer: ☐ Self ☐ Spouse ☐ Parent ☐ Significant Other **Insured Date of Birth**: _____ / _____ / _____

SECONDARY INSURANCE INFORMATION

Do you have insurance?: ☐ Yes ☐ No **Insurance Company**: _____
Insurance Group Number: _____ **Insurance Policy Number**: _____
Insurance Address (Street / P.O. Box): _____
City: _____ **State**: _____ **Zip Code**: _____
Insured Last Name: _____ **Insured First Name**: _____ **Middle Initial(s)**: _____
Relation to Insurer: ☐ Self ☐ Spouse ☐ Parent ☐ Significant Other **Insured Date of Birth**: _____ / _____ / _____

ASSIGNMENT OF INSURANCE BENEFITS – PLEASE COMPLETE WITH RECEPTIONIST AT CHECK-IN ON 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 undersigned had personally signed the particular claim.

I, _____ **hereby authorize** _____
Patient First & Last Name (PLEASE PRINT) **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 assignment.

Patient Signature: _____

Date: _____ / _____ / _____

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