PATIENT REGISTRATION

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

GUARANTOR 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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