



REGISTRATION FORM

(Please Print)

Today's date:							
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
IF PATIENT IS <u>NOT</u> THE INSURED:							
Subscriber's name:		Birth date: / /	Address (if different):			Subscriber's S.S. no.:	
Occupation:		Employer:		Employer address:		Employer phone no.: ()	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):			Relationship to patient:		Home phone no.: ()	Work phone no.: ()	
<p>I hereby request and consent to medical care for myself, including all examinations, tests, therapies, and other procedures which my physicians and their assistants or personnel deem necessary and appropriate. I acknowledge that no guarantees have been made as to the results of such medical care. I also agree to all of the terms and conditions described below.</p> <p>I acknowledge that I have received or previously received the Notice of Privacy Practice, which describes how medical information about me may be used and disclosed.</p> <p>It is understood and agreed that Hastings Imaging Center shall not be liable for the loss or damage to any personal property.</p> <p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hastings Imaging Center or insurance company to release any information required to process my claims.</p>							
<hr style="width: 100%;"/> <i>Patient/Guardian signature</i>						<hr style="width: 100%;"/> <i>Date</i>	