

PATIENT REGISTRATION

Dr. _____

Fax: _____

Last Name: _____ First: _____ MI: _____
 Address: _____ Apt: _____
 City: _____ State: _____ Zip: _____ Sex: M / F Age: _____
 Phone: H) _____ W) _____ C) _____
 SSN #: _____ DOB: (MM/DD/YY): _____ Weight: _____
 Marital status: (S) (M) (D) (W) Race: _____ Language: _____
 Ethnicity: _____ Email Address: _____
 Emergency Contact: _____ Phone#: _____

IF PATIENT IS A MINOR COMPLETE BELOW:

Parent/Guardian Name: _____ Relation to PT: _____ DOB: _____
 Address, if different: _____
 Phone: _____

Is this a work comp related Injury? YES or NO
 Is this a motor vehicle related injury? YES or NO

DATE OF INJURY: _____

CIRCLE RESPONSE TO BOTH QUESTIONS

Do you have an attorney for this injury? YES _____ No _____ If yes:
 Attorney Name: _____
 Attorney Address: _____
 Atty Phone: _____ Atty Fax: _____

PATIENT INSURANCE INFO:

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|| IF THIS IS A WORK COMP/AUTO ACCIDENT/LIEN/SLIP-IN-FALL,
 || PLEASE SKIP THE SECTION BELOW THIS BOX AND SIGN BOTTOM
 || OF THIS PAGE.
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Primary Ins. Co: _____ Subscriber Name: _____
 Relation to Pt: _____ Subscriber DOB: _____ Employer Name/Grp: _____
 ID#: _____ GRP #: _____
 Secondary Ins. Co: _____ Subscriber Name: _____
 Relation to Pt: _____ Subscriber DOB: _____
 ID#: _____ GRP#: _____

Insurance Billing: I hereby certify the information I have reported above with regard to my insurance coverage is correct and further authorize Upstate Radiology and/or Imaging Subspecialist of NY, PLLC to furnish my ins. company with all information which my ins. company may request concerning my present illness or injury. I hereby assign to Upstate Radiology and/or Imaging Subspecialist of NY, PLLC all money to which I am entitled for all expenses related to the service reported above. Direct Billing: If my insurance company denies coverage of the expenses related to the service date reported above, I will promptly pay such expenses. In addition, I will pay any costs incurred in collecting the amount of such expenses from me.

Patient Signature

Date

Office Staff Witness