PATIENT REGISTRATION

(Please print information and give your insurance card to the receptionist so a copy can be made. Thank you.)

Name: _____

Address: _____ Zip: _____ City: _____ State: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____

Social Security #: _____ Date Of Birth: _____ Sex: _____

Employment Status: (Please circle) Full Time PartTime Retired Self Employed Unemployed

Employer: _____ Address: _____

Marital Status: _____

Student Status: (Please circle) Full Time PartTime

Additional. Info: _____

Next Of Kin: _____ Emergency Contact: _____ Phone: _____

Person who should receive bill (guarantor or responsible party):

Name: _____ Relationship To Patient: _____

Address: _____ Zip: _____ City: _____ State: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____

Social Security #: _____ Date Of Birth: _____ Sex: _____

Employment Status: (Please circle) Full Time PartTime Retired Self Employed Unemployed

Employer: _____ Address: _____

PRIMARY

Ins. Name: _____ Policy #: _____

Ins. Address: _____

Ins. Phone: _____ Group #: _____ Group Name: _____

Subscriber: _____ Date Of Birth: _____ Relationship To Patient: _____

SECONDARY

Ins. Name: _____ Policy #: _____

Ins. Address: _____

Ins. Phone: _____ Group #: _____ Group Name: _____

Subscriber: _____ Date Of Birth: _____ Relationship To Patient: _____

TERTIARY

Ins. Name: _____ Policy #: _____

Ins. Address: _____

Ins. Phone: _____ Group #: _____ Group Name: _____

Subscriber: _____ Date Of Birth: _____ Relationship To Patient: _____

I understand that I am responsible for my bill. I authorize ROCK HILL RADIOLOGY ASSOCIATES, PA to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to ROCK HILL RADIOLOGY ASSOCIATES, PA. I authorize release of information necessary to collect any payments to all my insurance companies. I further authorize release of medical information to any and all physicians involved in my care. I permit a copy of this authorization to be used in place of the original. I authorize the use of the "signature on file" to be used on all of my insurance submissions. I understand that I am responsible for notifying the office of any precertification or referral needed for my insurance.

Signature Of Patient or Guardian _____ Date: _____