SouthSound RADIOLOGY

Patient Registration Form

Please complete this form and bring it to your appointment

(Please print all information)

Patient Name:_____

Birthdate: _____/____/_____ Age: _____ Sex: Male / Female

Responsible Party Name: _____(Relationship to patient)_____

Address: _____ Apt.#: _____ City, State, ZIP: _____

Home Phone:_____ Cell: _____ Work: _____

Email address:_____ May we contact you via email/text? Yes No

Patient's SS#:_____ Responsible party SS#_____

Referring Doctor Name:_____

Is this visit related to a work injury? (Please circle) Yes No Date of injury: _____

Is this visit related to an auto accident? (Please circle) Yes No Date of accident: _____

Are we billing an auto claim or Medical Insurance? (Please circle) Auto Medical

Auto Ins. Carrier Name: _____ Auto Claim #:_____

Adjuster's Name & Phone #: _____

Patient is: (Please circle) Single Married Employment Status: (Please circle) Full-Time Part-Time Un-employed

Employer Name & Address: _____

Primary Insurance Co. Name:_____ Policy #:_____

Group #: _____

Policy Holder Name: _____ Policy Holder Sex: M F Policy Holder DOB:_____/____/_____

Policy Holder Relationship to Patient: _____

Secondary Insurance Co. Name:_____ Policy #:_____ Group #: _____

Policy Holder Name: _____ Policy Holder Sex: M F Policy Holder DOB:_____/____/_____

Policy Holder Relationship to Patient: _____

How did you hear about us?

( ) Primary doctor ( ) Websearch ( ) Family/Friend ( ) Other: _____