

RENO DIAGNOSTIC CENTERS
Patient Registration

DATE OF BIRTH _____

PATIENT ACCT# _____

SS# _____
(REQUIRED - SEE BELOW IF PATIENT IS A MINOR)

MALE FEMALE

TODAY'S DATE: _____

REFERRING MD _____ EXAM TYPE: _____ NEW PATIENT EXISTING PATIENT

PATIENT'S NAME: _____
(LAST) (FIRST) (MIDDLE)

MAILING ADDRESS: _____
(STREET / BOX NUMBER) (CITY, STATE) (ZIP CODE)

TELEPHONE: HOME #: _____ WORK #: _____ MOBILE #: _____

EMPLOYER'S NAME: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

IS PATIENT A MINOR? YES NO *If Yes, please provide the required information below.*

NAME OF RESPONSIBLE PARTY: _____ SS#: _____
(REQUIRED)

MAILING ADDRESS (If different from patient): _____

EMERGENCY NOTIFICATION: NAME: _____ PHONE: _____

ADDRESS: _____ RELATIONSHIP: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

INSURANCE INFORMATION

PRIMARY INS. CO.: _____

SECONDARY INS. CO.: _____

NAME OF INSURED: _____

NAME OF INSURED: _____

RELATIONSHIP TO PATIENT: _____

RELATIONSHIP TO PATIENT: _____

DOB (Insured party): _____ SS #: _____

DOB (Insured party): _____ SS #: _____

EMPLOYER: _____

EMPLOYER: _____

GROUP NUMBER: _____

GROUP NUMBER: _____

POLICY NUMBER: _____

POLICY NUMBER: _____

WORKER'S COMPENSATION PATIENTS ONLY

IS THIS A WORK RELATED INJURY? YES NO

NAME OF WORKER'S COMPENSATION CARRIER: _____

DATE OF INJURY: _____ EMPLOYER AT TIME OF INJURY: _____

CLAIM NUMBER: _____ EMPLOYER'S PHONE NUMBER: _____

Financial Policy

All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. Payment for services is required at time of registration.

I authorize the release of my films to the referring physician(s) and/or consulting physician(s) as requested.

Patient/Parent or Guardian and/or Insured's Signature _____ Date _____

FOR OFFICE USE BELOW

Employee Initials: _____

Date: _____