1639 N. Volusia Avenue, Orange City, FL 32763
Phone: 386-774-7226 Fax: 386-774-7227

Patient Registration Form

Patient Information

Patient's Name: Last_____________________________ First __________________________ MI_______

Social Security #: ______-_____-______ Male ____ Female ____ Date of Birth _____/_____/_____

Address:____

City/State/Zip:____

Phone #: Daytime (____) _____-_______ Evening (____) _____-_______ Cell (____) _____-_______

E-mail address:____

Emergency Contact: _______________________________________Phone #: (____) _____-_______

Relationship to patient:____

Physician requesting exam: _______________________

Other physician to receive report:_________________

Primary Insurance (provide your insurance card to the front desk at check- in)

Name of Policyholder: ____________________________________

Patient Relationship to Insured: ____________________________

Policyholder date of birth: _____/_____/____ Policyholder Social Security #: ______-_____-______

Insurance Company Name: ____Phone#: (____) _____-______

Insurance Company Address: ____

Policy #: _____________________________Group#: ________________________

Claim#: _______________

Effective date: _____/_____/_____ Accident or Injury Date: ______/______/______

Is this an Auto Accident? □ Yes □ No Is this a Worker's Compensation claim: □ Yes □ No

Adjustor: ____ Adjustor phone#: (____) _____-_______

** You must notify your auto insurance adjuster of your motor vehicle accident for the claim to be processed. Failure to do so makes you personally responsible for your charges.**

Is an attorney involved? □ Yes □ No

Attorney Name: ____

Phone: (____) _____-_______

Address:____

Pregnancy Notice

There are unknown risks to an unborn fetus in any imaging study. If there is a chance that you may be pregnant, it is strongly recommended that you postpone any imaging studies until it can be confirmed that you are not pregnant.

I have read and understand the above statement. There is no chance that I am currently pregnant. Consequently, I am electing to have x-rays or other diagnostic imaging studies done at this time. I hereby release the ordering/attending physician, the imaging center and all of their physicians, agents and employees from all liability if it is determined that I am pregnant at this time.

____ __________________________

Signature of Patient or Personal Representative Date

Acknowledgement of Assignment of Benefits

I hereby acknowledge that I have received medical services from Advanced Imaging. In consideration of the services and treatment rendered, I hereby authorized and direct payment of medical benefits to Advanced Imaging and assign any and all causes of action that I may have against any insurance company (including all coverage for PIP and/or Med-pay, as a result of a vehicular accident), obligated to me by law, statute, or contractual agreement, for payment for such medical services and treatment. I direct my insurer to escrow any personal injury protection and/or medical payment benefits to disputes for services or treatments rendered to me by Advanced Imaging. I also understand that the medical services rendered by Advanced Imaging could have been obtained by other providers but chose to obtain said services and treatments from said facility. I also authorized the release of any pertinent information or medical records to Advanced Imaging, and any other medical provider, insurance company or attorney involved with my medical treatment or case and/or litigation, this is seeking to obtain payment for medical services and treatment rendered by Advanced Imaging or others on its behalf. I hereby direct my insurance company carrier to provide a copy of the PIP log or benefit payout sheet as well as any written explanations as to payments or reductions made or denied or other correspondence pertaining to a claim for services or treatment rendered to me as specified herein. A photocopy of this assignment shall be considered as valid and effective as the original.

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

____ __________________________

Signature of Patient or Personal Representative Date

****For the safety of our patients and staff the facility is under 24 hour surveillance.****