

# 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 recertification or referral needed for my insurance.

Signature Of Patient or Guardian \_\_\_\_\_ Date: \_\_\_\_\_