XRA MEDICAL IMAGING

# NEW PATIENT REGISTRATION

## PLEASE PRINT CLEARLY

Account # _____

Patient Name _____ Sex *(circle)* M F Date of Birth ___/___/___

Address _____ City _____ State _____ Zip _____

Employer/School Name & Address _____

Home Phone _____ Work Phone _____ S.S.# _____

If Minor, Parent / Guardian Name & Address _____

Referring Physician _____

## INSURANCE INFORMATION

Insurance # 1 _____ ID# _____

Insured's Name: _____ Relation to Patient _____ Date of Birth ___/___/___

S.S.# _____ Address (if different from patient) _____

Insurance # 2 _____ ID# _____

Insured's Name: _____ Relation to Patient _____ Date of Birth ___/___/___

S.S.# _____ Address (if different from patient) _____

Person responsible for any balances _____

Address (if different from patient) _____

## WORKMAN'S COMP / LIABILITY

*If today's exam applies to a Workman's Comp case or Liability case please fill this section out in its entirety.*

**WORKMAN'S COMP:**

Date of Injury ___/___/___ Claim # _____ Contact _____

Employer _____ Phone # _____

Address _____ City _____ State _____ Zip _____

W/C Insurance _____ Phone # _____

Address _____ City _____ State _____ Zip _____

**LIABILITY:**

Attorney Name _____ Phone # _____ Date of Injury ___/___/___

Address _____ City _____ State _____ Zip _____

## PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I certify the above information is true and accurate. I authorize the release of any medical or other information necessary to process a claim or continue medical treatment. I also authorize payment of medical benefits paid directly to XRA Medical Imaging. I acknowledge I am responsible for payment if my insurance company denies my claim.

_____

Signature Date