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.

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Signature Date