Diagnostic Imaging Specialists of Chicago

Patient Registration Form

MR# _____

NAME _____

LAST NAME (LEGAL) FIRST MIDDLE

DATE OF BIRTH _____ AGE _____ RACE (OPTIONAL) _____

HOME ADDRESS _____

CITY/STATE ZIP CODE

HOME PHONE (_____) _____ CELL PHONE (_____) _____ WORK PHONE (_____) _____

EMAIL ADDRESS _____

OCCUPATION _____EMPLOYER _____

HAVE YOU BEEN TO OUR OFFICE BEFORE? ☐YES ☐NO; IF YES, WHEN? _____
☐FOR ULTRASOUND ☐FOR MAMMOGRAM

TYPE OF EXAM YOU ARE HERE FOR TODAY: ☐ROUTINE MAMMOGRAM ☐PROBLEM MAMMOGRAM ☐ULTRASOUND
☐BONE DENSITY ☐OTHER_____

*REFERRING PHYSICIAN'S NAME _____

ADDRESS CITY/STATE ZIP

HOW DID YOU HEAR ABOUT OUR FACILITY? _____

*DR. FARAG IS NOT CONTRACTED WITH MEDICARE INSURANCE; DO YOU HAVE MEDICARE? ☐YES ☐NO

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY _____

NAME OF POLICY HOLDER _____ DATE OF BIRTH OF POLICY HOLDER _____

RELATIONSHIP OF POLICY HOLDER TO PATIENT (CHECK ONE) ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

ID NUMBER _____ GROUP NUMBER _____

I hereby authorize Diagnostic Imaging Specialists of Chicago, P.C. to release any information to my insurance company acquired in the course of my examination. I hereby authorize benefits to be paid directly to DISOC. I understand that I am fully responsible for any unpaid balance, and I understand that my insurance may deny benefits, thus making me responsible for any amount not paid. I also authorize DISOC to communicate /transmit test results by means of routine mail, electronic mail or fax transmissions. . I permit a copy of this authorization to be used in place of the original.

Authorization to Treat: I give consent to receive services by Diagnostic Imaging Specialists of Chicago, PC.

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*Signature of Patient or Authorized Representative Date