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 OR MEDICAID INSURANCE; DO YOU HAVE MEDICARE OR MEDICAID? YES ✔ NO**

INSURANCE

PRIMARY INSURANCE COMPANY _____

POLICY HOLDER _____ DATE OF BIRTH _____

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

ID NUMBER _____ GROUP NUMBER _____

OTHER INSURANCE COMPANY ☐ YES ☐ NO _____

POLICY HOLDER _____ DATE OF BIRTH _____

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

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 DISC. 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 DISC to communicate via SMS & 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.

_____ _____
***Signature of Patient or Authorized Representative** **Date**