



### PATIENT REGISTRATION FORM

Name \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Address \_\_\_\_\_ Driver's License # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Sex  Male  Female  
 Age \_\_\_\_\_ Birth date \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

### PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_  
 Relation to Patient \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ Phone Number \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
 Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Subscriber # \_\_\_\_\_  
**Please have your card available to be copied**

### ADDITIONAL INSURANCE

Is patient covered by additional insurance?  Yes  No Social Security #: \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birth date \_\_\_\_\_  
 Address (if different from patient's) \_\_\_\_\_ Phone Number \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Subscriber # \_\_\_\_\_  
**Please have your card available to be copied**

I hereby assign to Merced MRI Medical Group those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with treatment rendered. I request that payment of authorized benefits be made directly to Merced MRI Medical Group on my behalf.

I fully understand that I am financially responsible for any and all amounts not otherwise paid by my insurance carrier.

\_\_\_\_\_  
 Signature of Patient/Responsible Party Relationship Date