El Portal IMAGING CENTER

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