

# Opensided MRI of Laguna Hills

## PATIENT REGISTRATION

Please Print

Today's Date \_\_\_\_\_

### PATIENT'S

SOC. SEC. # \_\_\_\_\_ PATIENT \_\_\_\_\_

\_\_\_\_ Mr. \_\_\_\_ Miss. Last Name First Name Middle Initial

\_\_\_\_ Mrs. \_\_\_\_ Ms. Has Your Name Change Since Last Visit? \_\_\_\_ Yes \_\_\_\_ No Previous Last Name \_\_\_\_\_

Sex: \_\_\_\_ Male \_\_\_\_ Female Birth date: \_\_\_\_\_ Age \_\_\_\_\_ Home Phone \_\_\_\_\_

Address: \_\_\_\_\_ Apartment # \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Suite # \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_ Work Phone \_\_\_\_\_

Nearest Relative in Case of Emergency \_\_\_\_\_ Phone # \_\_\_\_\_

To the best of my Knowledge there (is) \_\_\_\_\_ (is not) \_\_\_\_\_ any indication that I may now be pregnant. \_\_\_\_\_

**INITIALS**

**PATIENT REFERRED BY DR.** \_\_\_\_\_

### PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT

Patient's relationship to person responsible for bill \_\_\_\_ spouse \_\_\_\_ child \_\_\_\_ other

Name \_\_\_\_\_ Employer \_\_\_\_\_

Mailing \_\_\_\_\_ Mailing \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_ City/State/Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

### INSURANCE AND/ OR INJURY AND/OR ATTORNEY INFORMATION

**PRIMARY INSURANCE** \_\_\_\_\_ **Secondary Insurance** \_\_\_\_\_

Employer # \_\_\_\_\_

IS THIS THE RESULT OF AN INJURY OR ACCIDENT? \_\_\_\_ WORK RELATED \_\_\_\_ OTHER ACCIDENT/INJURY \_\_\_\_ AUTO ACCIDENT \_\_\_\_

Date of Accident \_\_\_\_\_ If auto, claim number or policy number \_\_\_\_\_

Brief summary of accident: \_\_\_\_\_

### IF WORK RELATED INJURY: (If this is a LABOR & INDUSTRIES claim please complete)

Date of Injury \_\_\_\_\_ Cause of Injury \_\_\_\_\_

Employer at Time of Injury \_\_\_\_\_ Claim # \_\_\_\_\_

We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes and compels us to do so. You may see your record or get more information about it in this office.

If my account is turned over to collection, I agree to assume the responsibility for all collection cost.

ASSIGNMENT AND RELEASE: I hereby authorize that my insurance benefits be paid directly to this facility. I am financially responsible for any balance due. I also authorize the Doctor or Insurance Company to release any information required to process this claim.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_