

MRI Centers Patient Registration Form

Patient Information

Patient's Name (Last) _____ (First) _____ (MI) _____ Weight: _____
Date of Birth ____ - ____ - ____ S. S.# ____ - ____ - ____ Sex: M F Marital Status: _____
Address: _____ City _____ ST _____ ZIP _____
Home Phone (____) _____ Work Phone(____) _____ Cell Phone (____) _____

Employer / Insurance Information

Patient: Employment Status: Full Time Part Time Retired Not Employed Child
Employer Name: _____
Employer Address: _____ Phone: (____) _____
City _____ ST _____ ZIP _____

Primary / Cardholder if not patient:

Cardholder Name: _____
Relationship to Patient _____ DOB ____ - ____ - ____ SS# ____ - ____ - ____
Cardholder Address: _____ City _____ ST _____ ZIP _____
Employer Name _____
Employer Address _____ City _____ ST _____ ZIP _____
Work Phone (____) _____ Fax: (____) _____

Secondary / Cardholder if not patient:

Cardholder Name: _____
Relationship to Patient _____ DOB ____ - ____ - ____ SS# ____ - ____ - ____
Cardholder Address: _____ City _____ ST _____ ZIP _____
Employer Name _____
Employer Address _____ City _____ ST _____ ZIP _____
Work Phone (____) _____ Fax: (____) _____

Visit Information

Is this a work related injury? No Yes Injury Date: _____ Claim # _____
Is this a motor vehicle accident? No Yes Injury Date: _____ Claim # _____
If patient is a Minor, state your relationship
 Parent Legal Guardian Other(specify): _____
What influenced your decision to use the MRI Centers' services today: (check all that apply)
____ Referring Physician ____ Prior services at the MRI Centers ____ Insurance ____ Friend / Family suggested
____ Referred by another MRI Facility ____ Advertising (type) ____ Other _____

Emergency Contact Information

In case of Emergency, Please notify: _____ Relationship _____
Home Phone (____) _____ Work Phone (____) _____
Address: _____