PATIENT REGISTRATION FORM

****OFFICE USE ONLY****

TODAY'S DATE: _____ **MR#: _____**

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE #: (_____) _____-_____ **CELL PHONE#: (_____) _____-_____**

DATE OF BIRTH: _____ **SEX: ☐ MALE ☐ FEMALE**

ETHNIC GROUP:

- ___ ASIAN
- ___ AFRICAN AMERICAN
- ___ HISPANIC/LATINO
- ___ MIDDLE EASTERN
- ___ NATIVE AMERICAN
- ___ PACIFIC ISLANDER
- ___ OTHER
- ___ WHITE

RACE:

- ___ AMERICAN INDIAN
- ___ ASIAN
- ___ BLACK/AFRICAN-AMERICAN
- ___ HAWAIIAN-PACIFIC ISLANDER
- ___ WHITE
- ___ OTHER

LANGUAGE:

- ___ ARABIC
- ___ CANTONESE
- ___ ENGLISH
- ___ HEBREW
- ___ JAPANESE
- ___ KOREAN
- ___ MANDARIN
- ___ RUSSIAN
- ___ SPANISH

SOCIAL SECURITY #: _____-_____-_____

E-MAIL ADDRESS: _____

TYPE OF EXAM: _____

REASON FOR THE EXAM: _____

************************************INSURANCE INFORMATION************************************

Name of Insurance: _____ Member ID _____ Group # _____

Secondary Insurance: _____ Member ID _____ Group # _____

PRIMARY POLICY HOLDER (please check one)**: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER**

If different than the patient, please complete the following:

POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____

************************************EMERGENCY INFORMATION************************************

In case of emergency, please notify:

NAME: _____

RELATIONSHIP TO PATIENT: _____

TELEPHONE #: (_____) _____-_____

PATIENT'S SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT

I, the undersigned, acknowledge the receipt of a complete copy of Main Street Radiology's HIPAA PRIVACY NOTICE concerning the use or disclosure of my protected health information ("PHI") and consent to the release of any medical information about me (and any others for whom I can give consent to the extent permitted by law) by Main Street Radiology's health care providers and its staff to any other heath care providers involved in caring for me (or for others for whom I can give consent) to carry out diagnosis and treatment.

With your permission, we can communicate medical information to you or a designee by fax, e-mail and voicemail. Please sign and provide the appropriate information below allowing Main Street Radiology to do so on your behalf.

- ☐ Cell Phone Voicemail _____
- ☐ Work Phone _____
- ☐ Fax _____
- ☐ Unencrypted E-Mail _____

PRINT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

EMPLOYEE INITIALS_____