

# 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 health 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** \_\_\_\_\_