



PATIENT REGISTRATION

NAME: _____ DOB: _____ SEX: M/F _____

GUARDIAN'S NAME IF MINOR: _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP CODE: _____ SS# _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE# _____

EMPLOYER: _____ REFERRING PHYSICIAN: _____

PRIMARY INSURANCE _____ **SECONDARY INSURANCE** _____

ADDRESS: _____ ADDRESS: _____

GROUP #: _____ ID#: _____ GROUP #: _____ ID# _____

NAME OF INSURED: _____ NAME OF INSURED: _____

SS#: _____ SS# _____

DOB: _____ RELATIONSHIP: _____ DOB: _____ RELATIONSHIP: _____

EMPLOYER: _____ EMPLOYER: _____

Assignment of Insurance Benefits. Patients with insurances please read and sign: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance and any other health plans, to: **Fairbanks Community Imaging**. This assignment will remain in effect until revoked by me in writing; a photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges that are not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Consent for Treatment. I hereby authorize Fairbanks Community Imaging to provide me with diagnostic imaging services as requested by my health care provider. I have read, understood and agreed to the above financial policy for payment of professional fees. I understand that the patient is ultimately responsible for all professional fees.

Signature: _____ **Date:** _____