Progressive Diagnostic Imaging Patient Registration Form

Patient Name: _____ Today's Date: _____ DOB: _____
Home Address: _____ City: _____ Zip:_____
Emergency Contact: _____ Phone: _____
Mobile: _____ Home: _____ Work: _____
Reason for Exam: _____ Pregnant? Yes No

Primary Insurance Information

Insurance Co. Name:_____ Insured's Name:_____
Insured's DOB:_____ Member ID: _____

Secondary Insurance Information

Insurance Co. Name_____ Insured's Name _____
Insured's DOB_____ Member ID_____

INSURANCE/MEDICARE ASSIGNMENT OF BENIFITS

I _____, request that payment of benefits be made to Progressive Diagnostic Imaging, for any services furnished to me by the provider. I authorize any holder of medical information about me to release to my insurance company(s) any information needed to determine these benefits or the benefits payable for related services.

x_____ Date_____
Signature of Patient, Parent/Guardian

To further insure compliance with the "Health Insurance Portability and Accountability Act of 1996" Progressive Diagnostic Imaging L.L.C. requests your written authorization to release health care information to outside health care facilities and send results to specific care providers, at the discretion of the patient. I, _____, authorize Progressive Diagnostic Imaging L.L.C. to release copies on my clinical records in connection with my care and treatment on _____ to the following:

Doctor's Name _____Address: _____ Phone # _____

Name _____ Relationship:_____

Name_____ Relationship: _____

x_____ Date_____

Signature of Patient, Parent/Guardian