Grossman Imaging Centers
Community Memorial Health System

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Patient Registration

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Age: _____ Sex: _____ Marital Status: _____
Address: _____ City, State, Zip: _____
Daytime Phone:_____ Home Phone: _____
Cell Phone: _____ Social Security #: _____
Email: _____
Referring Doctor: _____ Employer: _____
Employer Address: _____ City, State, Zip: _____
Emergency Contact: _____ Emergency Contact Phone: _____

GUARANTOR INFORMATION

Name:_____ Social Security #:_____
Address:_____ City/State/ Zip: _____

PRIMARY INSURANCE COVERAGE

Insurance Name: _____ Insured's Name: _____
Address: _____ Group #: _____
City/State/ Zip:_____ Insured's ID #:_____
Relationship to Patient:_____ Insured's DOB: _____

SECONDARY INSURANCE COVERAGE

Insurance Name:_____ Insured's Name:_____
Address:_____ Group #:_____
City/State/ Zip:_____ Insured's ID #:_____
Relationship to Patient:_____ Insured's DOB:_____

Unless prior arrangements have been made with this office, ALL fees are due from ALL PATIENTS as services are rendered.

I hereby consent to examination and treatment deemed advisable by the professional staff at Grossman Imaging Center, and I agree that all records are and shall remain property of Grossman Imaging Center. I authorize, however, Grossman Imaging Center to furnish any information requested by an insurance company of the patient.

_____ _____

Patient Signature **Date**