# REGISTRATION FORM

| Today's Date: | Office use only: MR no.: |
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## Patient Registration

| Last Name: | First Name: | Middle: |
|---|---|---|
| Birth date: / / | Age: | Sex: M F |
| Address: | | |
| City: | State: | ZIP code: |
| Home phone no.: ( ) | Cell phone no.: ( ) | *Social Security no.: |
| Email: | Marital status: (circle one) Single / Married / Divorced / Widowed | |
| Employer: | Employer phone no.: ( ) | |
| Race: ___ Decline to Provide | Ethnicity: ___ Hispanic or Latino ___ Unknown | ___ Non-Hispanic or Non-Latino ___ Decline to Provide |

## Guarantor (Responsible Party) Information

| **Person responsible for bill:** | Birth date: / / | *Social Security no.: |
|---|---|---|
| Address: | | Phone no.: ( ) |
| Employer: | | Employer phone no.: ( ) |

## Insurance Information

| **Primary Insurance:** | Policy no.: | Group no.: |
|---|---|---|
| Subscriber's name: | Subscriber's relationship to patient: | Subscriber's Birth Date: / / |
| Insurance address: | | Insurance phone no.: ( ) |
| **Secondary Insurance:** | Policy no.: | Group no.: |
| Subscriber's name: | Subscriber's relationship to patient: | Subscriber's Birth Date: / / |
| Insurance address: | | Insurance phone no.: ( ) |

### Additional Contact Information

| Name of Emergency Contact: | Relationship to patient: | Phone no.: ( ) |
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All returned checks will be subject to a $20.00 processing fee.

***Insurance***: My signature below hereby authorizes the above named insurance company(s) to pay for all medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance company. I authorize release of medical information to said insurance company(s). Additionally, *my signature provides willing consent to the procedures which may be performed*.

***Authorization***: I understand that it is my referring care providers' and my responsibility to pre-certify my exam(s) with my insurance company and I understand that I am responsible for payment in the event that my insurance company denies this service. AUTHORIZATION TO RELEASE INFORMATION I hereby authorize MRIC to release any information or medical records to any physician, hospital, medical facility or insurance company dealing with my health care.

| **Patient/Guardian Signature:** | **Date:** |
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