



REGISTRATION FORM

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Sex: Female Male Marital Status: Single Married Divorced Widowed

Referring Physician: _____

Primary Physician: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Responsible Party

Name: _____ Relationship to Patient: Self Spouse Parent

Phone Number: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance: _____ Subscriber SSN: _____

Subscriber Name: _____ Subscriber DOB: _____

ID Number: _____ Group Number: _____

Secondary Insurance: _____ Subscriber SSN: _____

Subscriber Name: _____ Subscriber DOB: _____

ID Number: _____ Group Number: _____

Auto Accident / Workers Compensation:

Date of Accident: _____ How did it happen: Auto Work

Insurance Company Name: _____ Claim #: _____

Address: _____

Adjuster's Name: _____ Phone #: _____



PREVIOUS EXAMS RELATED TO YOUR VISIT TODAY:

Facility/Location: _____ Phone: _____
Exam: _____ Date of service: _____

RELEASE OF MEDICAL RECORDS

I authorize Tower Radiology, LLC to release my medical imaging records including my radiographs, professional interpretations, reports, and other medical information to the "Authorized Person" whose name appears below. I understand that anyone not listed below will not have access to medical information at Tower Radiology, LLC.

Name	Relation	DOB
1. _____	_____	____/____/____
2. _____	_____	____/____/____
3. _____	_____	____/____/____

X _____
Signature Date _____

X _____
Witness Date _____

FINANCIAL ARRANGEMENT:

I authorize Tower Radiology to release from my medical records any information required by my insurance carrier or any person, company, or agency responsible for processing my claims for medical services.

I authorize payment directly to Tower Radiology of all insurance or health plan benefits otherwise payable to me, to the extent of my bill. I acknowledge that I am financially responsible for charges not paid by my insurance or other agencies, and for any co-pays, deductibles and/ or coinsurance. If my account is placed with a third party in order to effect collection, I agree to be responsible for all costs of collection which may include but are not limited to: attorney fees, court costs, third party billing/credit reporting fees, collection agency fees including a 25% surcharge. (e.g. Suburban Credit Corporation), etc. I have read the notice of Privacy Practices in regards to HIPAA.

Signed: _____ Date: _____