

COOL SPRINGS IMAGING
PATIENT REGISTRATION (PLEASE PRINT)

What symptoms are you having? _____

Patient Name: _____ CHILD
Last First MI

Address: _____
Box # Street Name Apt# City State Zip

Home Phone: () _____ - _____ Cell/Work Phone: () _____ - _____

Date of Birth: ____/____/____ Social Security# _____ - _____ - _____

Marital Status: Single Married Other Sex: Female Male

Patient Ethnicity: Caucasian African American Hispanic Asian Other

Employer: _____ Phone: () _____ - _____

Employer Address: _____

Is this work related? yes no Date of injury: ____/____/____

Doctor who referred you to our office: _____

INSURANCE INFORMATION

Name of Primary insurance _____

Name of subscriber on insurance policy (If subscriber is a minor give parent / guardians information): _____

Patient relation to insured party: self (If self, skip to secondary insurance section) spouse child other

Subscribers address: _____ please check here if the same as patient

Box # Street Name Apt # City State Zip

Home Phone: () _____ - _____ Cell/Work Phone: () _____ - _____

Subscriber DOB: ____/____/____ SSN: ____/____/____

Subscriber Employer: _____ Phone: () _____ - _____

Name of Secondary insurance _____

Name of subscriber on insurance policy _____

Patient relation to insured party: self spouse child other

Subscribers address: _____ please check here if the same as patient

Box # Street Name Apt # City State Zip

Home Phone: () _____ - _____ Cell/Work Phone: () _____ - _____

Subscriber DOB: ____/____/____ SSN: ____/____/____

Subscriber Employer: _____ Phone: () _____ - _____

Emergency Contact: _____ Phone: () _____ - _____

I hereby authorize and consent to the radiology procedures ordered by my physician and performed at Cool Springs Imaging. I authorize the release of medical information to process insurance claims for office or hospital related charges. In addition, I direct and authorize payment to Cool Springs Imaging, in the event the insurance is filed. If this is a liability claim, I authorize and request that the insurance company and/ or the attorney pay Cool Springs Imaging directly from any settlement due me. I accept legal responsibility for any charges and agree to pay any legal/ collection expenses should my account become delinquent or be placed with an outside collection agency or attorney.

Patient's/ Guardian's Signature

Date