



Registration Form

PATIENT INFORMATION

Patient Last Name _____ First, MI _____ Sex _____
 Jacket # _____ Home Phone _____ DOB _____
 Social Security # _____ Marital Status _____

Address _____
 City _____ State _____ ZIP _____

Employer Name _____ Job Title _____
 Employer Address _____ Work Phone _____
 Employer City _____ State _____ ZIP _____

Emergency Contact Person (not living with you)
 Name _____ Phone _____
 Address _____

RESPONSIBLE PARTY INFORMATION

Name _____ Address _____
 Relationship _____ SSN _____ DOB _____
 Employer _____ Phone _____
 Address _____

INSURANCE INFORMATION

On the Job Injury? _____ Motor Vehicle Accident? _____

Primary Carrier

Carrier Name _____
 Address _____
 City _____ State _____ ZIP _____

Policy Holder _____ Policy # _____ Group # _____
 Authorization _____ Adjuster _____

Secondary Carrier

Carrier Name _____
 Address _____
 City _____ State _____ ZIP _____

Policy Holder _____ Policy # _____ Group # _____

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Envision Imaging of Arcadiana. I authorize the release of any medical information necessary for treatment by my current or future physician or health care provider. I authorize Envision Imaging of Arcadiana to release to my insurance company any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance company denies this claim, I will be held financially responsible for all charges.

I acknowledge that I have received a copy of Envision Imaging of Arcadiana's Privacy Notice. Initials: _____

Printed Name _____

Signed _____ Date _____