

Axiom Imaging of Las Vegas

PATIENT REGISTRATION

Today's Date _____

Please Print

PT'S SS. # _____ PATIENT _____
Last Name First Name Middle Initial

___ Mr. ___ Miss ___ Mrs. ___ Ms. Has your name changed since last visit? ___ Yes ___ No Previous last name: _____

Sex: ___ Male ___ Female Birth date _____ Age _____ Home Phone _____

Address _____ Apartment # _____

City/State/Zip Code _____

Patient's Employer _____ Occupation _____

Address _____ Suite # _____

City/State/Zip Code _____ Work Phone _____

Nearest Relative in Case of Emergency _____ Phone # _____

To the best of my knowledge there (is) ___ (is not) ___ any indication that I may now be pregnant. _____

INITIALS

PATIENT REFERRED BY DR. _____

PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT

Patient's relationship to person responsible for bill ___ spouse ___ child ___ other

Name _____ Employer _____

Address _____ City/State/Zip Code _____

Home Phone _____ Work Phone _____ Occupation _____

INSURANCE AND/OR INJURY INFORMATION

PRIMARY INSURANCE _____ Secondary Insurance _____

Group # OR Claim # _____ Subscriber's Name _____

ID # _____ ID # _____

Employer # _____

IS THIS THE RESULT OF AN INJURY OR ACCIDENT? ___ WORK RELATED ___ OTHER ACCIDENT/INJURY ___ AUTO ACCIDENT

Date of Accident _____ If auto, claim number or policy number _____

Brief summary of accident: _____

IF WORK RELATED INJURY: (If this is a LABOR & INDUSTRIES claim please complete)

Date of Injury _____ Cause of Injury _____

Employer at time of Injury _____ Claim # _____

We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes and compels us to do so. You may see your record or get more information about it in this office. If my account is turned over to collection, I agree to assume the responsibility for all collection costs. **ASSIGNMENT AND RELEASE:** I hereby authorize my insurance benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the Doctor or Insurance Company to release any information required to process this claim.

SIGNATURE: _____ **DATE:** _____