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?____
Email Address: ____

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: __________________________

If your provider is requesting a comparison to a prior study, it is the PATIENT'S RESPONSIBILITY to obtain and supply Tower Radiology with the prior images.

PLEASE LIST ANY **ALLERGIES**, I.E., LATEX, ETC. _______________________

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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 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: _____________________

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