Mammography Specialists Medical Group, Inc.

PATIENT REGISTRATION FORM

(All information must be completed in order to bill your insurance company)

Patient: _____ _____ _____
Last First MI

Date of Birth: _____ Gender (please circle): F M Marital Status: M S D W Sep

Soc Sec Number: _____ E-mail: _____

Office phone:_____Employer: _____

Home phone:_____ Cell phone: _____

Patient's Street Address: _____Apt # _____

City: _____ State:_____ Zip: _____

INSURANCE INFO (Must be filled out by patient – HIPAA requirement)

Primary Insurance Company (Please provide copy of card) : _____

HMO _____ PPO _____ POS _____

Subscriber: Last name _____First Name _____ MI _____

Subscriber's Birthdate: _____ Subscriber's Employer: _____

Subscriber's ID No: _____ Group No: _____ Relationship: _____

Secondary Insurance Company (Please provide copy of card): _____

HMO _____ PPO _____ POS _____

Subscriber: Last name _____First Name _____ MI _____

Subscriber's Birthdate: _____ Subscriber's Employer: _____

Subscriber's ID No: _____ Group No: _____ Relationship: _____

Referring Doctor(s):_____

Person to notify in an Emergency: _____ Phone: _____

I understand that I am liable for any expenses incurred which are not covered under my plan. I understand that all co-payments, deductibles, and/or non-covered services are to be paid **In Full** at the time of service. I hereby authorize the release of any information to my insurance company necessary to process claims. I hereby authorize my insurance company to make payments directly to Mammography Specialists Medical Group Inc. I may be billed for any missed appointments if I fail to notify the office at least 24 hours in advance. In the event a breast biopsy is done based on a recommendation from this facility, I hereby authorize release of my records and pathology reports to Mammography Specialists. I have read and agree to these policies and will abide by them.

Signed: _____ Date: _____

Print name: _____