FOR OFFICE USE ONLY

X-Ray #: ______________________ Date: _______________

Exam: ______________________ Time: _______________

PATIENT REGISTRATION

NAME:

LAST	FIRST	MI	SUFFIX

BIRTHDATE / /	AGE:	SEX: • MALE • FEMALE	S.S.#:

ADDRESS:	APT#:

CITY:	STATE:	ZIP:

HOME PHONE: ( )	WORK PHONE: ( )

MARITAL STATUS : S M W D SEP	EMPLOYMENT STATUS: EMP FT STUDENT PT STUDENT NOT EMP

PATIENT'S EMPLOYER NAME , CITY & ST:

REFERRING PHYSICIAN

REFERRING PHYSICIAN NAME:

STREET **OR** CITY WHERE YOU SEE THE PHYSICIAN:

PRIMARY CARE PHYSICIAN (PCP)

PCP NAME:

STREET **OR** CITY WHERE YOU SEE THE PHYSICIAN:

OTHER PHYSICIANS WHO REQUIRE A REPORT

1)

NAME	STREET OR CITY WHERE YOU SEE THE PHYSICIAN

2)

NAME	STREET OR CITY WHERE YOU SEE THE PHYSICIAN

PREGNANCY-RELATED INFORMATION - REQUIRED WHEN RADIOLOGY SERVICE IS RELATED TO PREGNANCY

PLEASE INDICATE IF YOU ARE PREGNANT: YES NO UNCERTAIN

IF YOU ARE PREGNANT, PLEASE PROVIDE THE DATE OF YOUR LAST MENSTRUAL PERIOD: / /

ILLNESS RELATED INFORMATION --REQUIRED WHEN RADIOLOGY SERVICE IS RELATED TO SYMPTOMS OR CLINICAL FINDINGS

APPROXIMATE DATE. IF YOU DO NOT KNOW THE DATE, THEN USE THE DATE OF YOUR VISIT TO THE PHYSICIAN WHO ORDERED THIS EXAM. DATE:
/ /

WERE YOU PREVIOUSLY TREATED FOR THESE SYMPTOMS: (circle) YES NO	DATE: / /

INJURY/ACCIDENT RELATED INFORMATION --REQUIRED WHEN RADIOLOGY SERVICE IS DUE TO INJURY OR ACCIDENT

INJURY/ACCIDENT DATE: / /	INJURY/ACCIDENT TIME: AM or PM

Please circle all (if more than one applies) of the following 'cause' codes that are related to the reason you are here today;

AA = Auto Accident AP = Another Party Responsible EM = Employment Related OA = Other Accident Cause

PLEASE CONTINUE ON THE REVERSE SIDE OF THIS FORM. THANK YOU.

PRIMARY INSURANCE

PLEASE COMPLETE THE DATE OF BIRTH, SEX OF THE INSURED AND THE PATIENT'S RELATIONSHIP TO THE INSURED.	/ /	M F	
	DATE OF BIRTH	SEX	PATIENT'S RELATIONSHIP

PLEASE COMPLETE THE REMAINING INFORMATION ABOUT YOUR INSURANCE, AND, PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST.

INSURANCE COMPANY:

POLICYHOLDER (Insured Party): • SELF or:

POLICYHOLDER: LAST NAME, FIRST NAME, MI

POLICYHOLDER ADDRESS:

POLICYHOLDER EMPLOYER/GROUP NAME:

POLICY/ID #:	GROUP #:

INS. ADDRESS:

STREET	CITY, STATE & ZIP

SECONDARY INSURANCE

PLEASE COMPLETE THE DATE OF BIRTH, SEX OF THE INSURED AND THE PATIENT'S RELATIONSHIP TO THE INSURED.	/ /	M F	
	DATE OF BIRTH	SEX	PATIENT'S RELATIONSHIP

PLEASE EITHER COMPLETE THE REMAINING INFORMATION ABOUT YOUR INSURANCE, OR, PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST.

INSURANCE COMPANY:

POLICYHOLDER (Insured Party): • SELF or:

POLICYHOLDER: LAST NAME, FIRST NAME, MI

POLICYHOLDER ADDRESS:

POLICYHOLDER EMPLOYER/GROUP NAME:

POLICY/ID #:	GROUP #:

INS. ADDRESS:

STREET	CITY, STATE & ZIP

PLEASE PRESENT YOUR INSURANCE CARD WITH THIS REGISTRATION FORM

GUARANTOR/FINANCIALLY RESPONSIBLE PARTY IF INSURANCE DOES NOT PAY (if other than patient)

GUARANTOR NAME:

FIRST NAME	MI	LAST NAME	SUFFIX

ADDRESS:		APT#:
CITY:	STATE:	ZIP:
HOME PHONE: ( )	WORK PHONE: ( )	
BIRTHDATE_____/_____/ _____	SEX: • MALE • FEMALE	

CONSENT FOR MINOR TO BE X~RAYED (Parent/guardian MUST sign below if the patient is under 18 yrs of age)

SIGNATURE PARENT/GUARDIAN	PRINTED NAME

AUTHORIZATION TO RELEASE MEDICAL INFORMATION, ASSIGNMENT OF BENEFITS, GUARANTEE OF PAYMENT

I request that payment of authorized Medicare or other insurance benefits be made either to me or on my behalf to Fairfax Radiological Consultants, PC for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services, its agents or other authorized parties any information needed to determine these benefits or the benefits payable for related services. I certify that the information I have reported with regard to my insurance coverage is correct. In the event my insurance does not cover this service, I agree to be responsible for payment.

SIGNATURE	DATE	PRINTED NAME