4045 E. Bell Road, Suite 143
Phoenix, Arizona 85032
Fax: 602-788-0893
602-867-0404

Please print all information

PATIENT REGISTRATION FORM

PATIENT NAME: ______________________________

RESPONSIBLE PARTY NAME: ______________________________

ADDRESS: ____________ Apt.#: ______ CITY, STATE, ZIP: ____________

PHONE: ____________ BUS. PHONE: ____________ CELL PHONE: ____________

SEX: Male Female BIRTHDATE: ____________ AGE: ______

WERE YOU INJURED ON THE JOB: Yes No DATE OF INJURY: ____________

REFERRING DOCTOR NAME: ______________________________

PATIENT S. S.#: ____________________

RESPONSIBLE PARTY S. S.#: ____________________ RELATIONSHIP TO PATIENT: ____________
(EX: SPOUSE, CHILD)

IS PATIENT: Married Single or Other IS PATIENT: Employed Full-Time Student or Part-Time Student

EMPLOYER NAME/ADDRESS ______________________________
INSURANCE INFORMATION:

PRIMARY INSURANCE
INSURANCE CO. NAME: ____________

INS. CO. ADDRESS: ____________

POLICY HOLDER NAME: ____________

RELATIONSHIP TO PATIENT: ____________

EMPLOYER: ____________

POLICY NO.: ______ GROUP/CLAIM NO.: ______

POLICY HOLDER SEX: Male Female

BIRTHDATE: ____________

SECONDARY INSURANCE:
INSURANCE CO. NAME: ____________

INS. CO. ADDRESS: ____________

POLICY HOLDER NAME: ____________

RELATIONSHIP TO PATIENT: ____________

EMPLOYER: ____________

POLICY NO.: ______ GROUP/CLAIM NO.: ______

POLICY HOLDER SEX: Male Female

BIRTHDATE: ____________

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of Desert Valley Radiology - 4045 E. Bell #137, Phoenix, AZ 85032, for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Desert Valley Radiology to release any information required in the course of my examination or treatment.

SIGNATURE: ______________________________ DATE: ____________