Affordable Medical Imaging Patient Registration Form

PATIENT INFORMATION:

Patient's Name:

_____

Last First MI

DOB: _____(MM/DD/YYYY) Age: _____Weight (lbs.): _____Gender: Male Female

(Circle Gender)

Address: _____

City: _____ State: _____Zip Code: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

EMERGENCY CONTACT INFORMATION: HOW DID YOU HEAR ABOUT US?

(Please circle your response)

Name: _____ Internet Newspaper Sign

Relation: _____ Phonebook TV Friend/Co-worker

Phone: _____ Mailing Referring Physician

Radio Other _____

PHYSICIAN INFORMATION:

Referring Physician: _____

Clinic:_____

Phone: _____ Fax: _____

Primary Physician: _____

Clinic: _____

Phone: _____ Fax: _____

HIPPA PRIVACY PRACTICE NOTICE

Affordable Medical Imaging, LLC is required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. I have been informed by Affordable Medical Imaging, LLC of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. By signing my name below, I acknowledge that I have received this Notice of Privacy Practices for review and I understand agree to its terms.

Patient Signature: _____ Date: _____

Staff Witness Signature: _____ Date: _____