Affordable Imaging Services Patient Registration

PATIENT INFORMATION:

Patient's Name: _____
Last, First, MI

DOB: _____ **Age:** _____ **Height (in):** _____ **Weight (lbs.):** _____ **Gender:** ☐ Male ☐ Female
(MM/DD/YYYY)

Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Email: _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

EMERGENCY CONTACT INFORMATION:

Name: _____
Relation: _____
Phone: _____

HOW DID YOU HEAR ABOUT US?

Internet ☐ **Social Media** ☐
Insurance Co. ☐ **Referring Physician** ☐
Radio ☐ **Friend/Co-Worker** ☐
Other ☐ _____

PHYSICIAN INFORMATION:

Referring Physician: _____
Clinic: _____
Phone: _____ **Fax:** _____
Primary Physician: _____
Clinic: _____
Phone: _____ **Fax:** _____

INSURANCE INFORMATION:

Provider: _____ **Policy Number:** _____
Policy Holders Name: _____ **Date of Birth:** _____
Relationship to Insured: _____

HIPAA PRIVACY PRACTICE NOTICE

Affordable Imaging Services, 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 Imaging Services, 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 and agree to its terms.

Patient Signature: _____ **Date:** _____

I give permission to email my medical records to me, my medical providers, or insurance for continuance of care, or for purpose of billing _____initials.