_____

CEDAR COURT IMAGING
PATIENT REGISTRATION FORM

PATIENT FIRST NAME_____ MI___ LAST NAME _____

DATE OF BIRTH _____/_____/_____ PATIENT SS# ___ ___ ___ / ___ ___ / ___ ___ ___ ___
month day year

SEX: ____ MALE ____ FEMALE

MAILING ADDRESS_____

CITY_____ ST_____ ZIP CODE_____

HOME PHONE NUMBER (_____) _____

WORK PHONE (_____) _____ CELL/ALT.PHONE (_____) _____

Responsible Party/Guarantor NAME_____
(insurance card holder)
RELATIONSHIP TO PATIENT_____

GUARANTOR SS# ____ ____ ____ / ____ ____ / ____ ____ ____ ____

PRIMARY INS. CO. _____ SECONDAY INS. CO. _____

DOCTOR WHO ORDERED YOUR TEST TODAY_____

ASSIGNMENT OF BENEFITS\MEDICAL RELEASE

I AUTHORIZE THE RELEASE OF ANY PAYMENTAND MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I REQUEST PAYMENT OF BENEFITS TO CEDAR COURT IMAGING.

_____ _____
PATIENT OR AUTHORIZED SIGNATURE DATE