



Registration Form

PATIENT INFORMATION

Patient Last Name _____ **First, MI** _____ **Sex** _____
Jacket # _____ **Home Phone** _____ **DOB** _____
Social Security # _____ **Marital Status** _____
Address _____
City _____ **State** _____ **ZIP** _____
Employer Name _____ **Job Title** _____
Employer Address _____ **Work Phone** _____
Employer City _____ **State** _____ **ZIP** _____
Emergency Contact Person (not living with you)
Name _____ **Phone** _____
Address _____

RESPONSIBLE PARTY INFORMATION

Name _____ **Address** _____
Relationship _____ **SSN** _____ **DOB** _____
Employer _____ **Phone** _____
Address _____

INSURANCE INFORMATION

On the Job Injury? _____ **Motor Vehicle Accident?** _____
Primary Carrier
Carrier Name _____
Address _____
City _____ **State** _____ **ZIP** _____
Policy Holder _____ **Policy #** _____ **Group #** _____
Authorization _____ **Adjuster** _____
Secondary Carrier
Carrier Name _____
Address _____
City _____ **State** _____ **ZIP** _____
Policy Holder _____ **Policy #** _____ **Group #** _____

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Outpatient Diagnostic Center. I authorize the release of any medical information necessary for treatment by my current or future physician or health care provider. I authorize Outpatient Diagnostic Center to release to my insurance company any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance company denies this claim, I will be held financially responsible for all charges.

I acknowledge that I have received a copy of Outpatient Diagnostic Center's Privacy Notice. Initials: _____

Printed Name _____

Signed _____ Date _____