



Welcome to our Imaging Center

Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_
Gender: O M O F Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_
Home Address: \_\_\_\_\_ City: \_\_\_\_\_
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Marital Status: O Single O Married O Minor O Other: \_\_\_\_\_
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_
If patient is minor, give parent/guardian (s) name (s): \_\_\_\_\_
Name of person child currently lives with: \_\_\_\_\_ Relationship: \_\_\_\_\_

Workers Comp

Insurance Carrier: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Adjuster: \_\_\_\_\_
Employer at time of accident: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Date of Injury: \_\_\_\_\_ Claim#: \_\_\_\_\_
Precertification # \_\_\_\_\_ Referral # \_\_\_\_\_

Assignment of Benefits

I hereby authorize payment of all health insurance benefits to Round Rock Imaging, Ltd and allow assignee to release all information necessary to secure payment. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. I will remit any payment made to me directly by my insurance carrier for services billed by Round Rock Imaging Ltd

I hereby authorize Round Rock imaging Ltd to furnish medical information concerning my present illness or injury to my family physician(s), referring physician(s), and insurance companies. I further authorize my family physician(s), referring physician(s), and other healthcare providers to furnish all medical information concerning my present illness or injury to Round Rock Imaging Ltd. .

I authorize the release of any necessary medical information to RRI, Ltd to assist in my diagnosis.

I have read, understood, and hereby consent to the MRI / CT / examination and the above conditions.

Patient or Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please present your picture id to the office staff

I hereby certify that all information on this Patient Registration form is true and correct.

Patient or Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_