# Garden Grove MRI Center

**PATIENT REGISTRATION** Today's Date _____
Please Print

**PATIENT'S**
**SOC. SEC. # _____ PATIENT _____**
Last Name First Name Middle Initial

___ Mr. ___Miss.

___ Mrs. ___Ms. Has Your Name Change Since Last Visit? ___Yes ___No Previous Last Name _____

Sex: ___ Male ____ Female Birth date: _____ Age _____ Home Phone _____

Address: _____ Apartment # _____

City/State/Zip Code _____

Patient's Employer _____ Occupation _____

Address _____ Suite # _____

City/State/Zip Code _____ Work Phone _____

Nearest Relative in Case of Emergency _____ Phone # _____

To the best of my Knowledge there (is) _____ (is not) _____ any indication that I may now be pregnant. _____
**INITIALS**

**PATIENT REFERRED BY DR**. _____

PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT

Patient's relationship to person responsible for bill _____ spouse _____ child _____ other

Name _____ Employer _____
Mailing Mailing
Address _____ Address _____

City/State/Zip Code _____ City/State/Zip Code _____

Home Phone _____ Work Phone _____ Occupation _____

INSURANCE AND/ OR INJURY AND/OR ATTORNEY INFORMATION

**PRIMARY INSURANCE** _____ Secondary Insurance _____

Employer # _____

IS THIS THE RESULT OF AN INJURY OR ACCIDENT? ___WORK RELATED ___ OTHER ACCIDENT/INJURY ___AUTO ACCIDENT___

Date of Accident _____ If auto, claim number or policy number _____

Brief summary of accident: _____

_____

**IF WORK RELATED INJURY:** (If this is a LABOR & INDUSTRIES claim please complete)

Date of Injury _____ Cause of Injury _____

Employer at Time of Injury _____ Claim # _____

We keep a record or the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes and compels us to do so. You may see your record or get more information about it in this office.

If my account is turned over to collection. I agree to assume the responsibility for all collection cost.
ASSIGNMENT AND RELEASE: I hereby authorize that my insurance benefits be paid directly to this facility. I am financially responsible for any balance due. I also authorize the Doctor or Insurance Company to release any information required to process this claim.

**SIGNATURE: _____ DATE: _____**