Vanderbilt Imaging Services

PATIENT REGISTRATION (PLEASE PRINT)

What symptoms are you having?_____

Doctor who referred you to our office:_____

Patient Name:_____ ☐ CHILD
Last First MI

**If Patient is a minor please list parent / guardians name & DOB:_____
Name Date of Birth

Address:_____
Box # Street Name Apt# City State Zip

Home Phone:_____ Cell/Work Phone:_____

Date of Birth: _____ Social Security#_____

Marital Status: ☐ Single ☐ Married ☐ Other Sex: ☐ Female ☐ Male

Patient Race: ☐Caucasian ☐African American ☐Hispanic ☐ Asian ☐Other:_____

Patient Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Other or Undetermined

Employer:_____Phone:_____

Employer Address:_____

Is this work related? ☐ yes ☐ no Date of injury:_____

Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION

Primary insurance:_____

Name of subscriber on insurance policy:_____

Patient relation to insured party:☐ self (If self, skip to secondary insurance section) ☐ spouse ☐ child ☐ other

Subscriber DOB (required):_____ Social Security#_____

Subscribers address: ☐ Please check here if the same as patient

_____
Box # Street Name Apt # City State Zip

Home Phone:_____ Cell/Work Phone:_____

Subscriber Employer:_____ Phone:_____

Secondary insurance:_____

Name of subscriber on insurance policy:_____

Patient relation to insured party: ☐ self ☐ spouse ☐ child ☐ other

Subscriber DOB (required):_____ Social Security#_____

Subscribers address: ☐ Please check here if the same as patient

_____
Box # Street Name Apt # City State Zip

Home Phone:_____ Cell/Work Phone:_____

Subscriber Employer:_____ Phone:_____

Email Address:_____

Please indicate below the type of information that may be shared at the email address you have indicated above:

☐ All ☐ Scheduling/Appointment ☐Billing/ Insurance ☐ Medical Record