SPRING HILL
IMAGING CENTER
Patient Registration Form (Please Print) Acct # _____

Appointment Date: _____

Doctor who referred you to our office: (First & Last Name if known)_____

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: _____ Age: _____ 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):	
Name of Subscriber:	Subscriber DOB:
Subscriber Address: Please check here if the same as patient ❑	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Subscriber ID: Subscriber Employer:
Secondary Insurance (name):	
Name of Subscriber:	Subscriber DOB:
Subscriber Address : Please check here if the same as patient ❑	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Subscriber ID: Subscriber Employer:

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