# PATIENT REGISTRATION

## PATIENT INFORMATION:

NAME: _____, _____, _____ SSN #: _____/_____/_____
Last First M.I.

ADDRESS: _____ _____, _____ _____
Street City State Zip

GENDER: ☐ MALE ☐ FEMALE DOB: ____/____/____ AGE: _____ MARITAL STATUS: _____

## CONTACT INFORMATION:

HOME: ____-____-_____ WORK: ____-____-_____ CELL: ____-_____-_____

EMAIL: _____

EMERGENCY CONTACT: _____ EMERGENCY PHONE: ____-____-_____

## CONSENT FOR ELECTRONIC BILLING & STATEMENTS

I understand that I will receive statements for any amount still owed after my insurance(s) have processed the claim(s) for services received by Lakeside MRI & Diagnostic Health. Please acknowledge that you have read and understand this.

Opt In ☐

Opt Out ☐

Initial _____

## RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME: _____, _____, _____ SSN #: _____/_____/_____
Last First M.I.

DOB: ____/____/_____