ADIRONDACK RADIOLOGY

PATIENT REGISTRATION INFORMATION

Date of Service: **Patient Name:** **MR#**

Address, City, State, Zip: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:**_____

Date of Birth: _____ **Social Security Number:** _____

Email Address: _____

Patient Employer: _____

Employer Address: _____

PLEASE ENTER (OR CONFIRM) INSURANCE INFORMATION

Responsible Party: _____

Primary Insurance: _____

ID#: _____ **Group#:** _____

Policy Holder: _____

Date of Birth: _____

Address: _____

Insured's Employer (and address): _____

_____

Secondary Insurance:_____

ID#: _____ **Group#:** _____

Policy Holder: _____

Date of Birth: _____

Address: _____

Insured's Employer (and address): _____

_____

Ethnicity: **Race:** **Preferred Language:**

X_____ _____ _____

Signature **Date** **Witness**