# Registration Form

## PATIENT INFORMATION

**Patient Last Name** ______________________ **First, MI** ______________________ **Sex** ______________
**Jacket #** ______________________ **Home Phone** ______________________ **DOB** ______________
**Social Security #** ______________________ **Marital Status** ______________________ **Alt #** ______________

**Address** ____________________________________________________________
**City** ______________________ **State** ______________________ **ZIP** ______________

**Employer Name** ______________________ **Job Title** ______________________________
**Employer Address** ______________________________________ **Work Phone** ______________
**Employer City** ______________________ **State** ______________________ **ZIP** ______________

*Emergency Contact Person (not living with you)*
**Name** ______________________ **Phone** ______________________________
**Address** ____________________________________________________________

## RESPONSIBLE PARTY INFORMATION

**Name** ______________________ **Address** ______________________________
**Relationship** ______________________ **SSN** ______________________ **DOB** ______________

**Employer** ______________________ **Phone** ______________________________
**Address** ____________________________________________________________

## INSURANCE INFORMATION

**On the Job Injury?** ______________________ **Motor Vehicle Accident?** ______________________

***Primary Carrier***

**Carrier Name** ____________________________________________________________
**Address** ____________________________________________________________
**City** ______________________ **State** ______________________ **ZIP** ______________

**Policy Holder** ______________________ **Policy #** ______________________ **Group #** ______________
**Authorization** ______________________ **Adjuster** ______________________________

***Secondary Carrier***

**Carrier Name** ____________________________________________________________
**Address** ____________________________________________________________
**City** ______________________ **State** ______________________ **ZIP** ______________

**Policy Holder** ______________________ **Policy #** ______________________ **Group #** ______________

## RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

**I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Envision Imaging of North Fort Worth. I authorize the release of any medical information necessary for treatment by my current or future physician or health care provider. I authorize Envision Imaging of North Fort Worth to release to my insurance company any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance company denies this claim, I will be held financially responsible for all charges.**

**I acknowledge that I have received a copy of Envision Imaging of North Fort Worth's Privacy Notice. Initials: ________**

**Printed Name** ________________________________________________

**Signed** ________________________________________________ **Date** ________________________