Elite IMAGING

REGISTRATION FORM - please print

PATIENT INFORMATION

Patient's last name: **First:** **Middle Initial:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)**	
			Single / Mar / Div / Sep / Wid	
Have you been treated at Elite Imaging under a different name? ❑ yes ❑ no **If so list name:**			**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F
Street address:	**Social Security no.:**		**Home phone no.:**	
			Cell #	
P.O. box:	**City:**	**State:**	**ZIP Code:**	
Occupation: ❑ Full time❑Part time ❑ Retired	**Employer Name and Address**		**Employer phone no.:**	

How did you hear about Elite Imaging ❑ Dr. ❑ Insurance Plan ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

PRIMARY INSURANCE INFORMATION

Person responsible for bill:	**Birth date:** / /	**Address (if different):**	**Home phone no.:** ( )
Occupation: ❑ Fulltime ❑ Part-time ❑ Retired		**Employer:**	
Employer address:		**Employer phone #:**	

Primary insurance Name:

Subscriber's name:	**Subscriber's S.S. no.:**		**Group no.:**		
Policy no.:		**Co-payment $:**			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

SECONDARY INSURANCE INFORMATION

NAME OF SECONDARY INSURANCE	**Subscriber's name:**		**Subscriber's S.S. #:**	
Birth date: / /	**Group #:**		**Policy #:**	
Occupation: ❑ Full time ❑Part time ❑Retired	**Employer:**		**Employer phone no.:**	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative	**Relationship to patient:**	**Home phone #:( )** **Work phone #: ( )** **Cell phone # ( )**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Elite Imaging of Fairview Heights. I understand that I am financially responsible for any balance. I also authorize Elite Imaging of Fairview Heights or insurance company to release any information required to process my claims.

Patient/Guardian signature	***Date***