Monticello Diagnostic Imaging
A Service of Wise Regional Health System

REGISTRATION FORM

(Please Print)

Today's date:	Referring Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is there a communication barrier? ❑ Yes ❑ No	Language Spoken:	Name of Spouse or Parent:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone and Cell phone no.: /

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Spouse's/Parent's Employer and Occupation: _____ Is there a communication barrier? ❑ Yes ❑ No

DOB: Social Security #: Phone no.: Relationship:

Other family members seen here:

INSURANCE INFORMATION

(Please give your identification card and insurance card to the receptionist.)

Guarantor:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ BC/BS ❑ Aetna ❑ Cigna ❑ PHCS ❑ UHC

❑ Medicare ❑ Medicaid ❑ Humana ❑ Tricare ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work/Cell phone no.: ( )

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

Patient/Guardian signature *Date*