



ARI PATIENT REGISTRATION FORM Date: ____/____/____

Patient's Name: _____

Date of Birth: ____/____/____ Social Security #: ____-____-____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) _____ Work/Cell Phone: (____) _____

PRIMARY INSURANCE

Insurance Co. Name: _____

Insured's Name (Circle One: Self, Spouse, or Parent): _____

Insured's Date of Birth: ____/____/____ Member ID#: _____ Group #: _____

SECONDARY INSURANCE

Insurance Co Name: _____

Insured's Name (Circle One: Self, Spouse, or Parent): _____

Insured's Date of Birth: ____/____/____ Member ID#: _____ Group #: _____

Pre-Certification(s): _____

Paid: (Circle One: Cash, Check, or Credit): \$ _____ Check #: _____

INSURANCE ASSIGNMENT OF BENEFITS

I, _____, Member ID# _____, request that payment of authorized benefits be made to Atlantic Radiologic Imaging, for any services furnished to me by the provider. I authorize any holder of medical information about me to release to my insurance company(s) any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ Date: _____

Legal Guardian: _____ Date: _____

Witness: _____ Date: _____

MEDICARE PATIENTS ASSIGNMENT OF BENEFITS

I, _____, Medicare # _____, request that payment of authorized Medicare benefits be made to Atlantic Radiologic Imaging, for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ Date: _____

Legal Guardian: _____ Date: _____

Witness: _____ Date: _____