



ARI PATIENT REGISTRATION FORM Date: _____

Patient's Name: _____

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

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

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

FOR NO-FAULT INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insured's Name: _____

Claim#: _____ Policy #: _____

Date of Accident: ____/____/____ Phone # of Contact Person: _____

FOR WORKERS COMPENSATION INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Employer's Name: _____ Employer's Phone: _____

Claim#: _____ Policy #: _____

Date of Accident: ____/____/____ Insurance Phone #: _____

NO-FAULT/ WORKERS COMPENSATION ASSIGNMENT OF BENEFITS

I understand that if my No-Fault/Workers Compensation insurance denies payment for services that have been rendered to me I will be financially liable for those services. In the event that my No-Fault/Workers Compensation insurance denies paying my claim, I authorize Atlantic Radiologic Imaging, to bill my major medical carrier for those services. I agree that if my major medical carrier refuses to pay for those services I will continue to be financially liable for the unpaid service.

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

MAJOR MEDICAL INSURANCE

Insurance Company Name: _____

Insurance Company Address: _____

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

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