OUTPATIENT RADIOLOGY REGISTRATION DOCUMENT

Name: _____ **Date of Birth** _____/_____/_____

Social Security number: __ __ __- __ __ - __ __ __ __

Address: _____
Street City State Zip Code

Phone: Home: (____) _____ **Cell:** (____) _____

Primary Care Physician: _____
Name Address Phone

Guarantor (if under 18) _____
Name Date of Birth

_____
Street City State Zip Code

_____
Phone Number Relationship to Patient Social Security Number

Primary Insurance

_____
Name of Insurance Insurance ID#

_____
Name of Subscriber Date of Birth Address

_____
Phone Number Relationship to Patient Social Security Number

Secondary Insurance

_____
Name of Insurance Insurance ID#

_____
Name of Subscriber Date of Birth Address

_____
Phone Number Relationship to Patient Social Security Number

FOR OFFICE USE ONLY:

☐ **Photo ID copied** ☐ **Insurance Card Copied** ☐ **Requisition Attached**

Type of X-ray: _____

Location of X-ray: _____

Date of X-ray: _____

AFTER INFORMATION HAS BEEN ENTRED INTO GLMI RIS PLACE ALL DOCUMENTS IN THE RADIOLOGY FOLDER IN PAULA'S MAILBOX.

Date Scanned to email to GLMI: _____