



Exam Date:	MRN:
	Secondary MRN:
CPT, Exam Description	

Patient Registration Information

Last Name		First Name		MI	Date of Birth	Sex
Address			City		State	Zip Code
Home Phone#	Work #	Cell#	Patient's Email			
Patient's Employer	Employer Address		City		State	Zip Code
Emergency Contact		Relation to patient		Emergency Contact Phone#		

Referring Physician		Referring Physician Phone #		Ref Physician Fax #	
Ref Physician Address		City		State	Zip Code

CC Physician:	CC Physician:
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Responsible Party (please write "same as above", if applicable)

Last Name		First Name		MI	Date of Birth	Sex
Address			City		State	Zip Code
Relationship	Phone#	Email		Employer		

Insurance / Payer

Authorization#

Insurance / Payer		Policy Number		Group Number	
Subscriber First Name	Subscriber Last Name		Date of Birth	Relationship	

Is there any possibility you are pregnant? YES NO Patient's initials: _____

Are you currently involved in a clinical trial study? YES NO Patient's initials: _____

I agree that all of the above information is true and correct.

Signature: _____

Parent/Legal Guardian Signature: _____

<p>For Office Use Only: Patient Name, Date of Birth, Exam & Physician have been verified. Front Office: _____ Tech(s): _____</p>
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For Blue Shield members only: Blue Shield members will receive two bills in the mail for their exams at Anaheim Hills Imaging Center. You will receive one bill from "Anaheim Hills Imaging Center, LLC." for the procedure and one bill from the Radiologist Practice for the reading fee.

This process is required by Blue Shield and NOT the facility.