



**PATIENT REGISTRATION FORM - Please Print**

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender \_\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Marital Status: Single / Married / Other Doctor who referred you to our office \_\_\_\_\_

Patient Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cell Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Email Address \_\_\_\_\_

**The information below is being collected pursuant to the requirements of the TN Department of Health in compliance with Tennessee state law.**

**Race:**       White/Black/American Indian       Eskimo or Aleut       Asian or Pacific Islander  
 Other Race       Unknown Race

**Ethnicity:**    Hispanic Origin       Not Hispanic Origin       Unknown if of Hispanic Origin

**Please check the appropriate box in answer to the following question. Have you executed an Advance Health Care Directive, a Living Will or Power of Attorney?**    Yes    No

**Guarantor (Complete if patient is under age of 18 years)**

Name: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

Guarantor-Employment Status:  Employed    FT Student    PT Student    Self Employed    Retired

Employer Name: \_\_\_\_\_ Employer Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

On the Job Injury: Y/N Motor Vehicle Accident: Y/N Accident/Injury Date: \_\_\_\_\_ State \_\_\_\_\_

**Workers' Compensation Insurance - If work related injury, please provide us the following information:**

WComp Insurance Name: \_\_\_\_\_ WComp Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Claim Number: \_\_\_\_\_ Case Manager \_\_\_\_\_

Adjuster \_\_\_\_\_ Authorized by: \_\_\_\_\_

**If this is a Motor Vehicle Accident see our Financial Policy regarding handling of claims.**

**HEALTH INSURANCE INFORMATION**

Check here to indicate you do **NOT** have Health Insurance Coverage as of this date.

**Primary Insurance** \_\_\_\_\_ Policy/Member Number \_\_\_\_\_

Plan Name \_\_\_\_\_ Group Number \_\_\_\_\_

Relationship: Self/Spouse/Child/Other      Subscriber Name \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_      Subscriber Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ Policy/Member Number \_\_\_\_\_

Plan Name \_\_\_\_\_ Group Number \_\_\_\_\_

Relationship: Self/Spouse/Child/Other      Subscriber Name \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_      Subscriber Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_

**If you are enrolled with Medicare, please circle your Medicare Enrollment Type:**

- 12 - Working Aged beneficiary/spouse with an employer group health plan
- 13 - End-Stage Renal Disease (ESRD) beneficiary in Medicare coordination period with an employer health plan
- 14 - No-Fault, including auto/other
- 15 - Worker's Compensation
- 16 - Public Health Service or other federal agency
- 41 - Black Lung
- 42 - Veteran's Administration
- 43 - Disabled beneficiary under age 65 with large group health plan
- 47 - Other Liability Insurance

**Request or Consent for Release of Medical Information or Records**

Name of Physician/Hospital You Are Requesting to Receive Records: \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Records/Information Requested \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release any and all medical information to:

- PREMIER RADIOLOGY** 28 White Bridge Pike • Ste. 111 • Nashville, TN 37205
- PREMIER RADIOLOGY** 5002 Crossing Circle • Ste. 140 • Mt. Juliet, TN 37122
- PREMIER RADIOLOGY PAIN MANAGEMENT CENTER** 28 White Bridge Pike • Ste. 104 • Nashville, TN 37205
- HERMITAGE IMAGING CENTER** 5045 Old Hickory Blvd • Ste. 100 • Hermitage, TN 37076

My signature indicates that all information reflected on this is form is true and accurate.

\_\_\_\_\_  
Signature of patient, responsible party or patient's representative

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Front Desk Initials \_\_\_\_\_