REGISTRATION FORM

Patient Information

Last Name		First Name		MI	
Birth Date		Social Security #		Sex	
Mailing Address		City, State		Zip	
Residential Address		City, State		Zip	
Home Phone #		Referring Phys Name		Ref Phys Tel #	
Cell Phone #		E-mail Address			
Employer Name		Phone #		Extension	
Emergency Contact		Phone #		Relation to Patient	

How did you hear about Northeast Radiology?

- ☐ Cable TV
- ☐ Our website (NERAD.com)
- ☐ Insurance
- ☐ Newspaper
- ☐ Radio
- ☐ Friend
- ☐ Other website ____________
- ☐ Physician

Are you a Skilled Nursing Facility resident? If YES, please provide the facility name:

Primary Insurance Information

Insurance Name		Policy #		Group #	
Address		City, State		Zip	
Policy Holder Name		Relationship to Patient		SS #	
Address		City, State, Zip		Date of Birth	
Employer Name		Phone #		Extension	
Address		City, State		Zip	

Secondary Insurance Information

Insurance Name		Policy #		Group #	
Address		City, State		Zip	
Policy Holder Name		Relationship to Patient		SS #	
Address		City, State, Zip		Date of Birth	
Employer Name		Phone #		Extension	
Address		City, State		Zip	

Signed Release

Northeast Radiology is hereby authorized to exchange (obtain/release) any medical records to another medical facility or healthcare provider, either by mail or electronically. I hereby authorize payment of medical benefits to Northeast Radiology for services performed. I understand I am responsible for payment. I hereby release Northeast Radiology of responsibility for claims denied for whatever reason. I further authorize Northeast Radiology to exchange all medical or other information necessary to determine these benefits or the benefits payable for related services.

Patient (Parent/Guardian) Signature		Date Signed	