FLORIDA RADIOLOGY CONSULTANTS
Your choice for advanced health imaging

Registration Form

Last Name	First	M I	Gender: M F
SSN	DOB	Marital Status	
Address 1			
Address 2			
City	State	Zip	
Day Phone ( )		Evening Phone ( )	

Responsible Party

Last Name	First	MI
SSN	DOB	
Relationship		
Address		
City	State	Zip

Emergency

Name
Relation
Phone

Employer

Employer Name		
Address		Phone
City	State	Zip

Injury

Date of Injury
Type
Claim #

How did you hear about us? Physician Referral ____ TV _____ Radio ____ Other ___

Billing Information □ **Self Pay** □ **Insurance** □ **Direct Bill**

Payer Name		Plan Name		
Address				
City	ST	Zip	Phone	
Subscriber relationship		Last	First	MI
DOB	Policy #		Group #	

Payer Name		Plan Name		
Address				
City	ST	Zip	Phone	
Subscriber relationship		Last	First	MI
DOB	Policy #		Group #	

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I also understand that if my balance is not paid in a timely manner it could also incur reasonable collection fees. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. I authorize release of my medical information to my referring physician via facsimile.

Signature_____