



REGENTS IMAGING

Patient Information

Patient Name: _____
 (last) (first) (middle initial) (DOB)

Section A

Primary Insurance Policyholder (If work comp. See Section C)

Subscriber Name: _____ Home Phone: _____
 Address: _____
 Employer's Name: _____ Employer's Phone _____
 Insurance Company Name: _____ Authorization #: _____
 Insurance Company Address: _____ Phone#: _____
 ID#/SSN: _____ Group/Plan #: _____
 Circle patient's relationship to policyholder: Self / Spouse / Child Other: _____

Section B

Secondary Insurance Policyholder

Subscriber Name: _____ Home Number: _____
 Address: _____
 Employer's Name: _____ Employer's Phone _____
 Insurance Company Name: _____ Authorization #: _____
 Insurance Company Address: _____ Phone#: _____
 ID#/SSN: _____ Group/Plan #: _____
 Circle patient's relationship to policyholder: Self / Spouse / Child Other: _____

Section C

Workers' Compensation Information

Is this a worker's compensation case? Yes No
 Name of employer at time of injury: _____ Phone#: _____
 Insurance Company Name: _____ Authorization #: _____
 Insurance Company Address: _____ Phone#: _____
 Claim # / SSN: _____ Date of Injury: _____
 Do you have an attorney? Yes No
 Attorney's Name: _____ Phone: _____

*** Photocopy of All Insurance Cards Is Required For Each Office Visit ***

Please enter your Social Security Number here ____ - ____ - ____
 This notice will be destroyed after entry into our HIPAA compliant billing system.

Signed By: _____ **Date:** _____