



REGENTS MRI

**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:** \_\_\_\_\_