REGISTRATION

Today's Date:

PATIENT INFORMATION

Last:	First:	Middle:	Legal Name: ◯ No ◯ Yes
Social Security:	Marital Status:	Birth Date:	Sex: M ◯ F ◯

Mailing Address: [Address/ P.O Box, City, ST ZIP Code]

Email:	Home phone no.:	Cell phone no.:

How did you hear about us?
(Please choose one option): ◯ **DOCTOR REFERRAL** ◯ **ADVERTISEMENT** ◯ **FRIEND REFERRAL** ◯ **OTHER**

INSURANCE INFORMATION

(Please give your insurance card & ID to the receptionist)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this a WORKERS COMPENSATION CASE?	◯ Yes ◯ No	CASE NUMBER:	ACCIDENT DATE:

Please indicate PRIMARY INSURANCE:

Subscriber's name:	Subscriber's S.S. no.:	DOB::	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Emergency Contact:	Relationship to patient:	Phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance or non-covered services. I authorize TETON SPORTS & SPINE IMAGING or my insurance company to release any information required to process my claims. I also release TETON SPORTS & SPINE to release my medical records to my physician's office or my insurance company without further written permission.

Patient OR Guardian Signature (relationship if other than patient) Date

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have been offered a copy of the Privacy Notice for Teton Sports & Spine Imaging.

Patient OR Guardian Signature **(relationship if other than patient)** **Date**

~~~~~~~Office Use: ~~~~~~

PAYMENT AT TIME OF SERVICE? YES / NO AMOUNT $ CASH / CHECK / CC PMT AUTH ATTACHED
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