Patient Registration Form

Appointment Date:____________________ Appointment Time______________

Patient Name:____

Mailing Address: ____

City:_________________________ State:___________________ Zip:_________

Phone:(_____) - _______-_______ Date of Birth___________________

Note: You must have a current Physician that we can send your report to. Please complete the following:

Physicians Full Name:____

Street: ____ Suite:______________

City: _____________________________ State:_______________ Zip:_________

Phone:(____) - ______-_______ Fax:(____) - _______-_______

Insurance Information

Insurance Company: ____

Group ID: ____

Policy Number: ____

Relationship to Policy Holder: ____

Authorization To Pay: I hereby authorize payment directly to the business office of Direct Medical Imaging, LLC, at 8824 Skymaster Drive, New Port Richey, FL 34654 for medical benefits, if any, otherwise payable for service. I understand that I am financially responsible for charges not covered by my insurance.

Signature:____ Date:_______________________