



PATIENT REGISTRATION

Last	First	MI	Also Known As: (maiden, nicknames, etc.)	
Street Address				Apt. #
City			State	Zip
Mailing Address (if different from above)				
Home Phone #		Cell Phone #		E-mail
Soc. Sec. #	Driver's License #	State	Date of Birth	Marital Status
Patient's Employment Status (circle one) Full-time Part-time Retired Not Employed				
Patient's Occupation			Employer	
Employer's Address			City	State
Address (continued)			Work Phone # (and extension)	May we call you at work? Yes <input type="checkbox"/> No <input type="checkbox"/>
Referring Physician (must have First and Last name)				Physician's Phone #
Family or Primary Physician, if different from above (must have First and Last name)				Physician's Phone #
Emergency Contact				
Name - Last		First		Relationship
Daytime Phone #		Evening Phone #		Pager # / Cell Phone #
Financial Information -- If you have insurance card(s) with you, you can omit this section				
Primary Insurance			Secondary Insurance	
Insurance Company Name			Insurance Company Name	
Name of Insured / Relationship		Group #	Name of Insured / Relationship	
Policy #		Group #		
Beginning Coverage Date		HMO or PPO	Beginning Coverage Date	
What is your co-pay amount?		HMO or PPO		
What is your co-pay amount?			What is your co-pay amount?	

How did you hear about Georgia Vein Specialists?

- | | | | |
|--|---|--|------------------------------------|
| <input type="checkbox"/> Dr's Referral | <input type="checkbox"/> Flyer | <input type="checkbox"/> Friend/former patient | <input type="checkbox"/> Billboard |
| <input type="checkbox"/> TV | <input type="checkbox"/> Healthfair | <input type="checkbox"/> Newspaper _____ | |
| <input type="checkbox"/> Website | <input type="checkbox"/> Magazine _____ | <input type="checkbox"/> Other _____ | |

AUTHORIZATION TO CONTACT ME: I authorize Quantum Radiology Northwest to contact me, either by phone or by mail to provide a reminder of an appointment, and/or information about any new technology or services that Quantum Radiology Northwest will be offering. Yes No

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I hereby acknowledge that Quantum Radiology Northwest has provided me a copy of their Privacy Notice.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS: The information above is accurate and true to the best of my knowledge. I authorize Quantum Radiology Northwest to file insurance claims on my behalf to Medicare or other insurance plans shown above. I understand that I am responsible for any deductible, co-payment, or non-covered service at the time that services are rendered. I authorize payment of any benefits due under my insurance plan to Quantum Radiology Northwest when insurance is filed on my behalf. I understand that I may be charged for missed office visits not canceled at least 48 hours in advance. I understand that it is my responsibility to understand the benefits of my insurance plan AND that I am financially responsible for any services not covered by my plan.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

I authorize Quantum Radiology Northwest to release any medical information pertaining to my diagnosis and treatment to 1) any requesting physician or medical facility providing my medical care; 2) my insurance plan, employer (if employer-funded plan), Medicare, or other payer/provider of medical benefits which may or will pay for part of my medical expenses. I understand that release of this information may be required in order to obtain payment for medical expenses. This authorization applies to all information regarding my care, which may include information otherwise privileged or confidential by law (including information related to psychiatric care, drug/alcohol abuse, and HIV/AIDS confidential information). I hereby release Quantum Radiology Northwest from any and all liabilities, which may arise from the release of the information described above. This authorization will remain in effect for ONE (1) YEAR from the date of my signature.

Patient Signature: _____ **Date:** _____