



PATIENT REGISTRATION



Name: _____ Date: _____
Last First MI

Sex: F M What would you like us to call you? Mr/Mrs/Ms Dr First Name Other: _____

DOB: _____ SSN: _____ Marital Status: S M W D Sep

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Work Status: Full Time Part Time Self Employed Retired Unemployed

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____

Phone: _____ Relationship to You: _____

Family/PCP Physician: _____ Phone: _____

Address: _____

Health Insurance Company: _____

Subscriber ID: _____ Group: _____

Was this a motor vehicle accident: Yes No Date of Injury: _____

Is this an L&I Claim? Yes No If yes, date of injury: _____ L&I Claim #: _____

Patient Signature: _____ Date: _____

Reason for today's consultation: _____

How did you hear about Via Radiology? _____

I authorize Via Radiology to send a copy of my consultation results to my family physician/PCP.

Patient Signature

_____/_____/_____
Date

* All billing statements will be issued by Via Radiology—Meridian Pavilion.