**REGISTRATION FORM**

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| |  |  | | --- | --- | | **Today’s Date:** | **Referring Physician:** |  PATIENT INFORMATION  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Last Name: | First Name: | | | Birth date: | Age: | Marital Status: | Sex: | | Address: | | City: | Zip | | | | | | | Social Security no.: | | Home phone no.: | Cell phone no.: | | | | | | |  | |  |  | | | | | |  INSURANCE INFORMATION(Please give your insurance card to the receptionist.)  |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  |   Please indicate primary insurance:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: | |  |  |  |  |  |  |   Patient’s relationship to subscriber:   |  |  |  |  | | --- | --- | --- | --- | | Name of secondary insurance (if applicable): | Subscriber’s name: | Group no.: | Policy no.: | |  |  |  |  |   Patient’s relationship to subscriber: IN CASE OF EMERGENCY  |  |  |  |  | | --- | --- | --- | --- | | Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: | |  |  |  |  |   **LIFETIME ASSIGMENT OF BENEFITS/ INFORMATION RELEASE/ AUTHORIZTION TO TREAT:**  I authorize payment of medical benefit to Pioneer Diagnostic & Research dba Pioneer Diagnostic & Imaging for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims.  I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge and fully understand that no guarantees, either expressed or implied have been made to me regarding the outcome of any treatments and or procedures. I have been given the opportunity to ask questions my treatment, the procedures used and alternatives available, if any. I have received a copy of Patients’ rights and responsibilities   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |  | Patient/Guardian signature |  | Date |  | |