Advanced Patient Imaging Patient Registration Form

PATIENT INFORMATION

Patient's Name:____
Last First MI

DOB: ________________(MM/DD/YYYY) Age: ______ Weight (lbs.):______ Gender: ❑Male / ❑Female

Address:____

City:______________________ State:__________ Zip:______________

Email:______________________________

Home Phone: (______)________________

Work Phone: (______)________________

Cell Phone: (______)________________

EMERGENCY CONTACT INFORMATION

Name: ____________________________

Relation: __________________________

Phone: ____________________________

HOW DID YOU HEAR ABOUT US?

❑ Internet ❑ Newspaper ❑ Sign
❑ Phonebook ❑ TV ❑ Friend/Co-Worker
❑ Mailing ❑ Community Event ❑ Radio
❑ Other:____________________________

PHYSICIAN INFORMATION

Referring Physician:_______________________________________

Clinic:_______________________________________

Phone: (______)________________ Fax: (______)________________

Primary Physician:_______________________________________

Clinic:_______________________________________

Phone: (______)________________ Fax: (______)________________

HIPAA PRIVACY PRACTICE NOTICE

Advanced Patient Imaging is required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. I have been informed by Advanced Patient Imaging of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. *Note: If you downloaded this form to fill out before your appointment, please download and review the Notice of Privacy Practices from our website and sign the Acknowledgement of Privacy Practices page and bring with you.*

By signing my name below I acknowledge that I have received this Notice of Privacy Practices for review and I understand and agree to its terms.

Patient Signature: ____________________________ Date:______________