ENVISION **IMAGING**
unmistakable quality . . . spectacular service

P 337.593.9500
F 337.593.0909
856-B Kaliste Saloom Road
Lafayette, LA 70508

REGISTRATION INFORMATION

Completing this form prior to your appointment enables us to expedite your registration time. Thank you.

PATIENT INFORMATION

PATIENT NAME Last _____ First_____ MI _____ ❍ Male ❍ Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Date of Birth _____ / _____ / _____ Social Security Number _____

Cell Phone _____ Employer _____ Work Phone _____ Ext. _____

Emergency Contact Person (not living with you) _____ Phone _____

RESPONSIBLE PARTY INFORMATION

Name_____ Address _____

City _____ State _____ Zip _____

Home Phone _____ Date of Birth _____ / _____ / _____ Social Security Number _____

Relationship to Patient _____ Employer _____ Work Phone_____ Ext. _____

INSURANCE INFORMATION

On the Job Injury? ❍ Yes ❍ No Date of Injury _____/_____/_____ Initial _____

Motor Vehicle Accident? ❍ Yes ❍ No Date of Injury _____/_____/_____ Initial _____

PRIMARY INSURANCE ❑ Insurance Card Present at the Time of Service

Insurance Company _____ Address _____

City _____ State _____ Zip _____ Phone Number _____

Policy Holder _____ **Address (if different than patient)** _____

Relationship to Patient _____ **Date of Birth** _____/_____/_____ **Social Security Number** _____

Policy # _____ Group # _____ Adjuster _____

SECONDARY INSURANCE ❑ Insurance Card Present at the Time of Service

Insurance Company _____ Address _____

City _____ State _____ Zip _____ Phone Number _____

Policy Holder _____ **Address (if different than patient)** _____

Relationship to Patient _____ **Date of Birth** _____/_____/_____ **Social Security Number** _____

Policy # _____ Group # _____ Adjuster _____

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Envision Imaging.

I authorize the release of any medical information necessary for the treatment by my current/future physician or health care provider.

I authorize Envision Imaging to release to my insurance company any medical information which may be necessary to process my insurance claim. I understand that in the event my insurance denies this claim, I will be held financially responsible for all charges.

I acknowledge that I have received a copy of Envision Imaging's Privacy Notice.
Initials: _____

Printed Name _____ Date _____ / _____ / _____

Signature _____