



MEDICAL PARK IMAGING
 AN IMAGING CENTER
 THAT'S CENTERED AROUND YOU.
 www.medicalparkimaging.com

WAYNE
 330 Ratzler Road
 Wayne, New Jersey 07470
 Phone: (973) 696-5770
 Fax: (973) 633-1204

DENVILLE
 282 Route 46 West
 Denville, New Jersey 07834
 Phone: (973) 625-3690
 Fax: (973) 625-5896

NEWFOUNDLAND
 2713 Route 23 South
 Newfoundland, New Jersey 07435
 Phone: (973) 697-1755
 Fax: (973) 697-5762

PATIENT REGISTRATION

Account #: _____ Any possibility of pregnancy? Yes No
 Consent for Diagnostic Procedure? Yes No
 Patient Name: _____ Signature: _____
 Birth Date: _____ Age: _____
 Sex: _____ Hght: _____ Wght: _____
 Address: _____ Social Security Number: _____
 City, State: _____ Has patient had previous X-rays here?
 Zip Code: _____ (Circle One) Yes No
 Home Phone: _____

REFERRING DOCTOR INFORMATION

EMPLOYER INFORMATION

Name: _____
 Street Address: _____
 City, ST Zip: _____
 Phone Number: _____

Name: _____
 Address: _____
 City, ST Zip: _____
 Phone Number: _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Name: _____
 Address: _____
 City, ST Zip: _____
 Phone #: _____
 Policy #: _____
 Group #: _____
 Policy Holder: _____
 DOB: _____ Sex: _____
 Employer: _____
 Relationship: _____
 Effective Date: _____

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Medical Park Imaging for services furnished. I authorize Medical information to be released to the HCFA or other insurance carrier, where information is needed to determine benefits payable. I understand I am financially responsible for all charges unless other arrangements have been made in advance. In some cases medical procedures may not be covered by my medical policy. In those cases I understand I am fully responsible for the uncovered procedure or any portion thereof not covered by my carrier.

Signature: _____ Date: _____