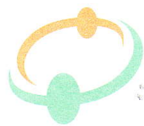

MEDICAL PARK IMAGING
AN IMAGING CENTER
THAT'S CENTERED AROUND YOU.
www.medicalparkimaging.com

WAYNE
330 Ratzer Road
Wayne, New Jersey 07470
Phone: (973) 696-5770
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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 #:

Patient Name: ____________________

Address: ____________________
City, State: ____________________
Zip Code: ____________________
Home Phone: ____________________

Any possibility of pregnancy? Yes No
Consent for Diagnostic Procedure? Yes No
Signature: ____________________

Birth Date: __________ Age: __________
Sex: ______ Hght: ______ Wght: __________
Social Security Number: __________
Has patient had previous X-rays here?
(Circle One) Yes No

REFERRING DOCTOR INFORMATION

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

EMPLOYER INFORMATION

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

PRIMARY INSURANCE

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

SECONDARY INSURANCE

____
____
____
____
____
____
____
__________ Sex: __________
____
____
____

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: ____________________