RIVER OAKS
MRI & DIAGNOSTIC

Patient Registration Form

Today's Date: _____

PATIENT INFORMATION: All information needs to match specifically to the information your insurance has on file for you.
Last Name: First name: Middle Initial:
Suffix: (Example: Jr. Sr. III) Patient Status: ____Single ____Married ____Other
Date of Birth: _____ / _____ / _____ Sex: _____Female _____ Male
Social Security #:
Mailing Address or P.O. Box Street:
City: State: Zip Code:
Home Phone: ( ) - Work Phone: ( ) -
Mobile Phone: ( ) - Email Address:
Emergency Contact Name: Phone:
If the patient is a minor (under 18 years of age), please complete the following:
Responsible Party/Guardian/Guarantor: Relationship:
Mailing Address or P.O. Box Street:
City: State: Zip Code:
Home Phone: ( ) - Work Phone: ( ) -
Mobile Phone: ( ) - Email Address:

INSURANCE INFORMATION: **All information needs to match specifically to the information your insurance has on file for you**. A photo ID and all insurance cards are required to be presented to Registration for each visit.
Primary Insurance Insurance Company Name:
Policy Number: Group number:
(Policy Holder Information)
Last Name: First name: Middle Initial:
Employer:
Suffix: (Example: Jr. Sr. III) Sex: _____M _____F Social Security #:
Date of Birth: _____ / _____ / _____
Secondary Insurance Insurance Company Name:
Policy Number: Group number:
(Policy Holder Information)
Last Name: First name: Middle Initial:
Employer:
Suffix: (Example: Jr. Sr. III) Sex: _____M _____F Social Security #:
Date of Birth: _____ / _____ / _____
As a patient of River Oaks MRI & Diagnostic L.L.C., I acknowledge that I had the opportunity to review River Oaks MRI & Diagnostic Notice of Privacy Practices, as required by HIPAA. I understand I may request a paper copy of this policy to keep. Initial: _____

Turn the page

17191 St Lukes Way, Suite 110, The Woodlands, TX 77384 - Phone: 281-720-8600 | Fax: 281-720-8610

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If you would like another individual (family or other) to have access to your medical records and/or to pick up your medical images and/or reports, please list the persons you authorize to do so below.
Name(s) _____
You, or others having your permission, will be required to present a photo I.D. when picking up Medical Records

Patient/ Guardian Signature: _____

Consent & Acknowledgement
I authorize River Oaks MRI & Diagnostic L.L.C. to release any medical or other information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original. If assignment is accepted, I request payment of insurance benefits be made directly to River Oaks MRI & Diagnostic L.L.C. I am responsible for the deductible, co-payment, and non- covered service (as determined by my insurer.) I understand that any deductible or coinsurance payments made on this exam date are estimates based on information River Oaks MRI & Diagnostic L.L.C. received from my insurance company prior to submission of the claim for this exam. Once a claim is submitted to my insurance carrier for the exam, I understand that I may be responsible for additional amounts in accordance with my individual insurance plan and acknowledge that River Oaks MRI & Diagnostic will bill me for the balance remaining. I authorize release of information, films, and copies pertinent to my medical history and for follow-up of any suspicious finding. This consent authorizes River Oaks MRI & Diagnostic to release my medical records to my insurance company, referring physician and other physicians participating in my care, including images and reports. If there are any physicians or persons that you would like to designate as NOT ALLOWED to access your medical record, including images and reports, please list them below:

_____

River Oaks MRI & Diagnostic has permission to call and leave a message regarding any medical history, results, or my patient information on the voice mail or answering machine for the numbers listed above.
Initial: _____

The following questions are GOVERNMENT REQUIRED for the HITECH Act
(Health Information Technology for Economical and Clinical Health)
(We are required to ask.)

Race? ____Caucasian ____American Indian/Native American ____Asian
____ African American ____Hawaiian/Pacific Islander ____Unknown Other: _____

Language? ____English ____Spanish ____Arabic ____Cantonese ____Hebrew
____Japanese ____Korean ____Mandarin ____Russian ____Unknown
Other: _____

List any medications you are currently taking: _____

List any food or drug/medication allergies: _____
_____
Type of reaction: _____

Smoking history: (**AGES 13 AND OLDER)**
____Unknown ____Everyday ____Occasional ____Former Smoker ____Never a Smoker

(FEMALES ONLY- AGES 40-69)
Have you ever had a mammogram to screen for breast cancer? ____Yes ____No

(AGES 50-75)
Have you ever had a colonoscopy for colorectal cancer? ____Yes ____No

(AGES 64 AND OLDER)
Have you ever had pneumonia (pneumococcal) vaccine? ____Yes ____No

Patient/Guardian Signature: _____ Date: _____

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