ASSOCIATION OF ALEXANDRIA RADIOLOGISTS, PC

PATIENT REGISTRATION

alexandriaradiology.com

PLEASE BRING YOUR DOCTOR'S ORDER, YOUR INSURANCE CARD AND DRIVER'S LICENSE/IDENTIFICATION TO YOUR APPOINTMENT.

PLEASE COMPLETE THIS ENTIRE FORM INCLUDING PRIMARY & SECONDARY INSURANCE BOXES.

Patient Name: _____
LAST FIRST MIDDLE

Address: _____
NUMBER & STREET CITY ZIP

Phone Numbers (Home) _____ (Cell) _____

Date of Birth: _____ SS#: _____ ○ Male ○ Female

Status: ○ Child ○ Married ○ Single ○ Divorced ○ Widowed

E-Mail: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Employer: _____

Employer Location: _____ Phone: _____

INSURANCE–PRIMARY

Insurance: _____

ID/Policy#: _____ Group#: _____

Insured Name: _____

Date of Birth: _____ Ins'd SS#: _____

Relationship: _____

INSURANCE–SECONDARY

Insurance: _____

ID/Policy#: _____ Group#: _____

Insured Name: _____

Date of Birth: _____ Ins'd SS#: _____

Relationship: _____

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SUBMIT