PARKVIEW IMAGING
PATIENT REGISTRATION

Personal Information

Last Name First Name

SS# DATE OF BIRTH AGE Driver's License

(P.O. box Unaccpitable)

Home Address

City State Zip

Home Phone# Work Phone #

Employer Address

City State Zip

Referring Physician Referring Physician

please circle the payment option that applies

work-comp private ins attorney lien self pay auto ins(med-pay)

Insurance information Must Be Completed If You Want Our Office To Bill Your Insurance

primary	secondary
Insurance Company	Insurance Company
Address	Address
City/State/Zip	City/State/Zip
Telephone #	Telephone #
Name of Insured Person	Name of Insured Person
Group #	Group #
Insured's ID#	Insured'd ID#
Relationship to the Insured	Relationship to the Insured
Telephone # of Insured Person	Telephone # of Insured Person

Emergency Contact: Relationship Phone #

I hereby authorize payment to be made directly to Westside Professional Management, Inc./ Parkview Imaging for all services rendered. I understand that I am financially responsible for all charges whether my insurance or attorney pays the bill.
I also understand that I will be responsible for 1% per month interest that may accrue on all unpaid balances. I also authorize the release of medical information to my insurance company for payment of all charges incurred with this facility. If legal action should become necessary to settle my account, I agree to pay all attorney and collection ageny fees.
I also authorize the release of all medical reports to all physicians responsible for my medical care.

Patient Signature Date