Bellevue Medical Imaging, PLLC
Bellevue Women's Imaging, PLLC
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REGISTRATION FORM

Legal Name: ____ Gender (circle one): M F
First M.I. Last

Date of Birth: _________________ Social Security #: ____

Address: ____

(**City**, **State**, **Zip**) ____

Home Phone: ____

May we leave messages on this number? (circle one) Yes No

Cell or Alternate Phone: ___________________________________

May we leave messages on this number? (circle one) Yes No

Emergency Contact Name: ______________________________ Phone Number: ________________________

******You do not need your insurance card to fill out the following section******

Primary Insurance Information

Are you the primary subscriber? (circle one) Yes No

IF NO, the information below is REQUIRED:

Primary Subscriber's Name: ________________________________ Date of Birth: ________________________

Insured's Relationship to Subscriber: ________________ Subscriber's Employer: __________________________

Secondary Insurance Information

Are you the primary subscriber? (circle one) Yes No

IF NO, the information below is REQUIRED:

Primary Subscriber's Name: ________________________________ Date of Birth: ________________________

Insured's Relationship to Subscriber: ________________ Subscriber's Employer: __________________________

By signing below, I consent to have an exam today at Bellevue Medical Imaging. I authorize the release of any medical or other information necessary to process insurance claims billed on my behalf. I also authorize payment directly to the doctor for any benefits available under my insurance plan. I understand that I am financially responsible for any non-covered charges and charges incurred by a collection agency in collecting any unpaid balances.

Patient or Guardian Signature: ____________________________________ **Date:** ______________________

OFFICE USE ONLY: ________ Verified patient ID
(initials)