Forsyth Imaging Center Patient Registration Form

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Email Address:	Cell Phone:		Work Phone:
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text			If Voice, Please Select Preferred Number: ☐ Home ☐ Cell
Family Physician or Pediatrician:	Date of Birth:		Sex: ❑ Male ❑ Female
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Name & Phone #:			Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information

Reason for Today's Visit

Can we leave a message regarding your medical care & test results? ☐ Yes ☐ No

Referral Information

Referring Doctors Name and Contact Information:	How Will Images Be Provided to the Referring Doctor?
Referring Doctor's Name:	o Emailed to Doctor
Phone:	o Emailed to Patient
Fax:	o USB Drive
Email Address:	o Don't Know

AUTHORIZATION TO CONTACT ME: I authorize Forsyth Imaging Center to contact me, either by phone or email to provide a reminder of an appointment and/or information concerning services that will be performed.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I hereby acknowledge Forsyth Imaging Center has provided a copy of their Notice of Privacy Practices to me.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY: Payment is due in full at the time of service. I understand I may be charged a $25 fee for a missed appointment if not cancelled with a 48 hour notice.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize Forsyth Imaging Center to release any medical information pertaining to my diagnosis and treatment (including scans) to any requesting physician or medical facility providing my medical or dental care. This authorization applies to all information regarding my care, which may include information otherwise privileged or confidential by law. I hereby release Forsyth Imaging Center from any and all liabilities, which may arise from the release of The information described above. This authorization will remain in effect for ONE (1) year from the date of your signature below.

I have reviewed a copy of Forsyth Imaging Center's Notice of Privacy Practices. ☐ **(Initials)**

Signature of Responsible Party: X _____ **Date:** _____

Printed Name of Responsible Party: X _____ **Date:** _____