Big Sky Diagnostic Imaging of Billings

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Birth Date _____ Age _____

Employer Name _____ Patient SSN _____

Employer Address _____ E-Mail _____

City _____ State _____ Zip _____ ❑ Male ❑ Female

Employer Phone _____ ❑ Married ❑ Single

❑ Unemployed ❑ Disabled ❑ Retired Referring Physician _____

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____

Subscriber Name _____ Subscriber Name _____

Birth Date _____ SSN _____ Birth Date _____ SSN _____

Group # _____ ID # _____ Group # _____ ID # _____

RESPONSIBLE PARTY (Spouse / Parent / Guardian)

Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Birth Date _____

Employer Name _____ SSN _____

Employer Address _____ Employer Phone _____

City _____ State _____ Zip _____ Relationship _____

EMERGENCY CONTACT

Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Relationship _____

WORK RELATED INJURY

Is your injury work related? ❑ Yes ❑ No

Date of Injury _____

Work Comp Carrier _____

Employer at Time of Injury _____

Claim# _____

Contact Person _____

Attorney Name _____

AUTO / OTHER INJURY

Injury due to accident? ❑ Yes ❑ No

Date of Accident _____

Accident Location _____

Insurance company _____

Claim # _____

Contact person _____

Attorney Name _____