SOUTHWEST MEDICAL IMAGING

Main Phone: (480) 425-5000
www.eSMIL.com

Registration Form

Legal Name: _____
(Last Name) *(First Name)*

Date of Birth: _____ Gender: _____ Primary Phone:_____ Email: _____

Address: _____
(Unit) *(City)* *(State)* *(Zip Code)*

Primary Insurance

Insurance Name: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Holder's DOB: _____ Relationship: _____

Secondary Insurance

Insurance Name: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Holder's DOB: _____ Relationship: _____

Tertiary Insurance

Insurance Name: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Holder's DOB: _____ Relationship: _____

Minor Patients Please **Print** Parent/Guardian's Name: _____

HIPAA

Release of/Request for Information Authorization
SMIL/SDI may disclose all or part of the patient's medical and/or financial records to your insurance plan of benefit eligibility, to referring physicians, other healthcare providers responsible for proving continued patient care and to any personal representative of the patient who is involved in the patient's care. We may request health information relating to imaging studies performed by SMIL. This may include, but not limited to, previous films/cds, symptoms/history, laboratory results, pathology reports, etc. Any objections to disclosures must be provided in writing to SMIL.

Notice of Privacy Practices Acknowledgement
SMIL follows the guidelines as stated in our *Notice of Privacy Practices* and *Patient Bill of Rights*. Please acknowledge by signing below that you have received/been offered the *Notice of Privacy Practices* and *Patient Bill of Rights* of SMIL. The notice can also be found at www.eSMIL.com. You may decline to complete or execute this acknowledgement.

_____ _____
Patient/Responsible Party Signature *Date*

Possibility of Pregnancy
(*Female Patients pubescent through menopause*)

Last Menstrual Period:_____ Possibility of Pregnancy: ☐Yes ☐No Patient's Initials: _____

Adopted 01/09/10 (Revised 11/30/23)