

Registration Form

Legal Name: _____
 (Last Name, First Name)

Date of Birth: _____ **Gender:** _____ **Primary Phone:** _____ **E-mail:** _____

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 providing 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 Initial:** _____