PATIENT REGISTRATION:
INFORMATION UPDATE

BELLINGHAM ADVANCED MEDICAL IMAGING

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial(s): _____

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Billing Address (Street / P.O. Box): _____

City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Insurance Company: _____

Insurance Group Number: _____ Insurance Policy Number: _____

Patient Relation to Insurer: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ In-Law ☐ Friend ☐ Significant Other

Insured Last Name: _____ Insured First Name: _____ Middle Initial(s): _____

*IF INSURANCE CARRIER'S INFORMATION IS THE SAME AS THE ABOVE PATIENT INFORMATION, PLEASE WRITE "SAME AS ABOVE": _____

*Insured Billing Address (Street / P.O. Box): _____

*City: _____ *State: _____ *Zip Code: _____

*Insured Employer: _____ *Work Phone Number: (_____) _____ - _____ ext. _____

ASSIGNMENT OF INSURANCE BENEFITS – PLEASE COMPLETE WITH RECEPTIONIST AT CHECK-IN ON DATE OF YOUR EXAM

I hereby assign all medical and / or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to **Bellingham Advanced Medical Imaging.** This assignment will remain in effect until revoked by me in writing; a photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges that are not paid by said insurance; I hereby authorize said assignee to release all information necessary to secure payment.

CONSENT FOR TREATMENT

I hereby authorize **Bellingham Advanced Medical Imaging** to provide me with diagnostic imaging services as requested by my health care provider. I have read, understood and agreed to the above financial policy for payment of professional fees. I understand that the patient is ultimately responsible for all professional fees.

Patient Signature: _____ Date: _____/_____/_____

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