iCare Diagnostic Imaging, LLC
2781 Freeway Blvd
Suite 160
Brooklyn Center, MN 55430

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last name: First: Middle:			
Social Security no. - -	Marital status (circle one) Single / Married / Divorce / Widowed	Age:	Sex (circle one) Male Female
Home address:			Home phone no.: ( )
Is the patient a minor? (circle one) Yes No	If yes, parent/guardian name:		
Emergency contact (name and phone #):			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance Company name:	Primary insured:	Primary insured's address (if different):	
Relation to patient:	DOB:	Group #	Policy #
Secondary Insurance company name:	Group#	Policy #:	

AUTO INJURY / WORKERS COMPENSATION

Type of accident: Work Related (circle one): Yes No		Date of injury
Claim # :	Adjuster:	Phone # :
Employer at time of injury :		Work phone :
Employer address:		

ATTORNEY INFORMATION

Type of accident:	Date of accident:
Attorney name:	Phone: ( )
Attorney Address :	

Patient Signature	Relation to patient:	Date: