



Houston MRI

Diagnostic Radiology of Houston

PATIENT REGISTRATION FORM
Phone: 713.425.8100 • Fax Orders: 713.425.8182

- 2600 N. Gessner, Ste. 150, Houston, TX 77080
- 5630 E. Sam Houston Pkwy N., Houston, TX 77015
- 1336 Pin Oak Road, Katy, TX 77494

PATIENT INFORMATION

Name: _____ SS# _____ - _____ - _____
First Name MI Last Name

DOB: ____/____/____ Age: ____ Sex: M F Single Married Widowed Divorced

Home Address: _____ Home Phone: _____ - _____ - _____

City: _____ State: ____ Zip: _____ Cell Phone: _____ - _____ - _____

Is patient a minor? Yes No If yes, parent/guardian name: _____

In case of emergency, who should we notify? _____ Phone: _____ - _____ - _____

Your email address: _____

Who may we thank for referring you? _____

PRIMARY INSURANCE

Primary Insured: _____

Primary Insured's Address: _____ City: _____ State: ____ Zip: _____

Relation to Patient: _____ DOB: ____/____/____ SS# _____ - _____ - _____

Do you have secondary insurance? Yes No If yes, Insured's Name/DOB: _____
 Please Provide Insurance Card.

WORKERS COMPENSATION

Type of Accident: Work Related? Yes No Date of Injury: ____/____/____

Claim #: _____ Adjuster: _____ Phone: _____ - _____ - _____

Employer at time of injury: _____ Work Phone: _____ - _____ - _____

Employer Address: _____ City: _____ State: ____ Zip: _____

ATTORNEY GUARANTEE

Type of Accident: Work Auto Other Date of Accident: ____/____/____

Attorney Name: _____ Phone: _____ - _____ - _____

Attorney Address: _____ City: _____ State: ____ Zip: _____

Houston MRI has accepted your Letter of Protection from your attorney. The letter of protection that your attorney has provided only postpones the payment of these services to the time of settlement of your case. Ultimately these charges will need to be paid in full and are your responsibility.

HIPPA COMPLIANCE

I have read and understand the HIPPA Privacy Practice document. A copy will be provided upon my request.

 Responsible Party Signature Print Name Relationship to Patient Date