Patient Registration Form | 2024

Patient Last Name: _____ MI: _____ First Name: _____ Birth Date: _____

Social Security Number: _____ Age: _____ Home Phone:_____

Sex: Female☐ Work Phone: _____

Male ☐ Cell Phone: _____

Address: _____ City: _____State: _____ Zip Code: _____

IN CASE OF EMERGENCY

Friend or relative: _____Relationship to patient: _____Contact number: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize SonoCare, LLC or insurance company to release my information required to process my claims.

_____ _____

Patient/Guardian Signature ***Date***

If you need your images and are unable to pick them up, you authorize the release of records to the individual(s) listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Your results will automatically be sent to your doctor

This authorization provides that:

- **I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.**
- **I have the right to access my protected health information to be used or disclosed.**
- **I have the right to receive a copy of this completed and signed authorization form.**

_____ _____

Patient/Guardian Signature ***Date***

Relationship to the patient (if signed by a representative of the patient)