



Patient Registration Form

Welcome to Houma Medical Imaging, LLC. We are committed to providing the most comprehensive care possible. Please assist us by providing the following information. All information is confidential. Also, please provide us with your insurance cards and ID so that we can make a copy for your file. (Also, please read and sign our financial policy statement.)

Date: ____ / ____ / ____

HMI Chart # _____

Patient Information

Patient Name: _____ Birthdate: ____ / ____ / ____

Social Security # ____ / ____ / ____ Sex: _____

Parent or Guardian (if patient is minor): _____

Address: _____

City: _____ State: _____ Phone: _____

Mailing Address (if different than above): _____

City: _____ State: _____ Zip: _____

Employer Information

Employer: _____ Employer Phone: _____

Employer Address: _____ City _____ State _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Cell Phone: _____ Work Phone: _____

Insurance Information

Insurance Name: _____ ID # _____

Insured or Subscriber Name: _____ Birthdate: ____ / ____ / ____ SS# ____ / ____ / ____