Diagnostic Imaging Center of Terrebonne

a TGMC affiliate

Patient Registration Form

Date:_____/_____/_____ DICOT Chart #:_____

Patient Information

Patient Name: _____ Birthday:____/____/____

Social Security #: _____-_____-_____ Sex: Male or Female

Parent or Guardian (if patient is a minor): _____

Address: _____

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

Mailing Address (if different than above):_____

City: _____ State: _____ Zip:_____

Emergency Information

Name: _____ Relationship:_____

Phone: _____

Insurance Information

Insurance Name: _____ ID #:_____

Policy Holder:_____ Relationship to Patient: _____

Policy Holder Birthday:_____/_____/_____ Policy Holder SS#: _____-_____-_____

Policy Holder Employer:_____