RADCON

9601 Baptist Health Drive, Ste 1100
Litte Rock, AR 72205
Main Number (501) 227-5240
Fax Number (501) 227-4735

PATIENT REGISTRATION

_____

FIRST NAME MIDDLE INITIAL LAST NAME SUFFIX (Sr., Jr., etc.)

_____

DATE OF BIRTH GENDER SOCIAL SECURITY NUMBER MARITAL STATUS

_____

ADDRESS CITY STATE ZIP CODE

(____)_____ (_____)_____ _____

CELL PHONE # TEXT (YES or NO) HOME PHONE # E-MAIL ADDRESS

_____(____)_____

EMERGENCY CONTACT PHONE #

WE WILL MAKE COPIES OF ALL INSURANCE CARDS, BUT WE REQUIRE THE FOLLOWING INFORMATION:

PRIMARY INSURANCE: _____ PRIMARY INSURANCE ID # _____

POLICY HOLDER NAME: _____ DOB: _____ SSN: _____

RELATIONSHIP TO THE PATIENT: (circle) SELF SPOUSE MOTHER FATHER OTHER _____

POLICY HOLDER EMPLOYER: _____

SECONDARY INSURANCE: _____ SECONDARY INSURANCE ID # _____

POLICY HOLDER NAME: _____ DOB: _____ SSN: _____

RELATIONSHIP TO THE PATIENT: (circle) SELF SPOUSE MOTHER FATHER OTHER _____

POLICY HOLDER EMPLOYER: _____

I understand I am financially responsible for the services provided by Radiology Consultants of Little Rock. My insurance will be filed on my behalf if my complete and accurate insurance information is provided. I understand if my insurance requires a co-pay/coinsurance, I am expected to pay at the time of service. If complete insurance information is not provided, I understand I will be billed directly. If I do not have insurance, 20% of payment at the time of service. Monthly payments and payment plans are available by calling the Billing Department at (501) 227-5130.

I hereby authorize payment directly to Radiology Consultants of Little Rock, the radiology benefits herein specified and otherwise payable to me. I hereby authorize Radiology Consultants of Little Rock to release any information requested by the insurance company to pay this claim. I also authorize any previous films, reports and/or lab results to be released to Radiology Consultants of Little Rock, if needed, to aid in my treatment.

_____ _____

SIGNATURE OF PATIENT (OR REPRESENTATIVE) DATE

Is this patient a minor (less than 18 years of age)? YES_____ NO _____
If "yes", please provide the following responsible party information:

_____

FIRST NAME MIDDLE INITIAL LAST NAME SUFFIX (Sr., Jr., etc.)

_____

SOCIAL SECURITY NUMBER DATE OF BIRTH

_____

ADDRESS CITY STATE ZIP CODE

(____)_____ (_____)_____ _____

CELL PHONE # TEXT (YES or NO) HOME PHONE # E-MAIL ADDRESS

Is this visit related to a work injury or motor vehicle accident?
If "yes", please complete the following:

☐ **Work Related Injury**

_____ _____

EMPLOYER DATE OF INJURY

_____ _____

INSURANCE NAME CLAIM NUMBER

_____

MAILING ADDRESS CITY STATE ZIP CODE

_____ (____)_____

ADJUSTER/CLAIMS MANAGER NAME PHONE NUMBER

☐ **Motor Vehicle Accident Insurance**

_____

DATE OF INJURY

_____ _____

INSURANCE NAME CLAIM NUMBER

_____

MAILING ADDRESS CITY STATE ZIP CODE

_____ (____)_____

ADJUSTER/CLAIMS MANAGER NAME PHONE NUMBER

**Motor vehicle insurance claims will be filed with the Third-Party Motor Vehicle Insurance Company. Until claim is paid, the patient is financially responsible for all bills and will receive statements, texts/calls from our billing department. **