DIAGNOSTIC IMAGING
735 Perryville Road, Rockford, IL 61107
(815) 398-1300
www.forestcitydi.com

PATIENT REGISTRATION FORM

Fax
(815) 398-3797

Patient Name: ______________________ (Last and Suffix, i.e. Jr.,Sr.) __________________ (First) _____ (MI) Date of Birth: ___/___/___

Social Security # ______________-___________-______________ Gender (Circle One): Male Female

Address: ____ City: ___________________________

State: ____________ Zip: ______________ Marital Status: Single _____ Married _____ Other _____

Home Phone: (______) ______________________ Work Phone: (______) _______________________

Cell Phone: (______) ________________________

EMPLOYMENT INFORMATION

Employer Name: ____

Employer Address: ____

Status: Full Time ______ Part Time ______ Retired ______ Unemployed ______

GUARANTOR INFORMATION

(Individual responsible for payment if other than patient)

Patient Relationship to Guarantor: Spouse _____ Child _____ Other _____

Name: ________________________ (Last) _____________________ (First) _____ (MI) Date of Birth _____/_____/_____

Social Security # ______________-___________-______________ Gender (Circle One): Male Female

Address: ____ City & State: ___________________________

Zip: ______________ Home Ph: (______) ________________ Work Ph: (______) __________________

Insured's Employer: ____

Employer Address: ____

Employment Status: Full Time ______ Part Time ______ Retired ______ Unemployed ______

Emergency Contact: ____________________________________ Phone (______)__________________

Relationship to Patient: ____

PLEASE REMEMBER WE NEED A COPY OF YOUR INSURANCE CARD