Bellevue Medical Imaging, LLC
1400 116th Ave NE, Bellevue, WA 98004
Phone (425)454-1700 ~ Fax (425)454-0600

PATIENT REGISTRATION FORM

Legal Name: _____ Gender (circle one): M F
First M.I. Last

Date of Birth: _____ Social Security #: _____

Address: _____

(**City**, **State**, **Zip**) _____

Home Phone: _____

May we leave messages on this number? (Circle one) Yes No

Cell or Alternate Phone: _____

May we leave messages on this number? (Circle one) Yes No

Email Address: _____

Emergency Contact Name: _____ Phone Number:_____

******You do not need your insurance card to fill out the following section******

Primary Insurance Information

Are you the primary subscriber? (Circle one) Yes No

IF NO, the information below is REQUIRED:

Primary Subscriber's Name: _____ Date of Birth: _____

Insured's Relationship to Subscriber: _____ Subscriber's Employer: _____

Secondary Insurance Information

Are you the primary subscriber? (Circle one) Yes No

IF NO, the information below is REQUIRED:

Primary Subscriber's Name: _____ Date of Birth: _____

Insured's Relationship to Subscriber: _____ Subscriber's Employer: _____

By signing below, I consent to have an exam today at Bellevue Medical Imaging. I authorize the release of any medical or other information necessary to process insurance claims billed on my behalf. I also authorize payment directly to the doctor for any benefits available under my insurance plan. I understand that I am financially responsible for any non-covered charges and charges incurred by a collection agency in collecting any unpaid balances.

Patient or Guardian Signature: _____ Date: _____